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RELATIONSHIP OF OBESITY TO CORONARY DISEASE AND HYPERTENSION

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For many years, the relationship between obesity and heart disease and hypertension has presented a challenging problem. The physiological effects of obesity on the normal heart and its harmful influences on the diseased heart are well established.[1]

Statistics compiled by insurance companies have shown conclusively that overweight alone is injurious and shortens life.[2] In middle and later life the lowest mortality ratios were observed in those whose weight was below the average for age.[3] There is overwhelming evidence, also, that obese persons have a much higher mortality rate from heart disease than those of average or lower weight. The difference has been as high as 60% for men who are 25% or more overweight.[4]

There have been few clinical studies on a possible etiological relationship between obesity and coronary disease and hypertension, and the results reported have been conflicting. The problem of the relationship of obesity to heart disease and hypertension is important because both conditions are widespread. In a study of 10,000 unselected persons, 28% were found to be 10% or more above their ideal weight, according to sex and height.[5]

The relationship of obesity to hypertension requires further investigation because of the recent proposal of new standards of hypertension by Master, Dublin, and Marks.[6] They investigated the blood pressure in 74,000 persons gainfully employed in 16 industrial plants and air force fields (civilian personnel), and 16,000 of these readings were used as a sample for statistical analysis.

In our report we shall present data concerning the frequency of obesity in coronary disease and hypertension in a large series of cases. We have used the limits of normal blood pressure recently proposed.[6] We also employed, as controls, the new weight tables obtained in the large series of gainfully employed persons (table 1) by comparison with the standard weight tables established in 1912.[7] This large series is representative of the present general population. It will be noticed that, after the age of 40, women are definitely more obese than men (table 1).

TABLE 1.—*Classification of Employed Persons by Weight and Age*

Age and Weight Group	Men, % of Total	Women, % of Total
20-29, Total	100.0	100.0
Underweight, 10% or more	22.5	28.5
Average weight	55.0	50.8
Overweight, 10-24%	16.6	11.2
Overweight, 25% or more	5.9	9.5
30-39, Total	100.0	100.0
Underweight, 10% or more	27.2	26.7
Average weight	48.9	43.6
Overweight, 10-24%	17.5	15.1
Overweight, 25% or more	6.4	14.6
40-49, Total	100.0	100.0
Underweight, 10% or more	32.9	28.4
Average weight	47.8	43.0
Overweight, 10-24%	14.0	16.0
Overweight, 25% or more	5.3	12.6
50-59, Total	100.0	100.0
Underweight, 10% or more	35.3	29.7
Average weight	46.7	42.0
Overweight, 10-24%	13.5	16.7
Overweight, 25% or more	4.5	11.6
60-64, Total	100.0	100.0
Underweight, 10% or more	33.8	34.0
Average weight	44.0	40.0
Overweight, 10-24%	12.6	16.7
Overweight, 25% or more	4.6	9.0
Total, all ages (20-64)	100.0	100.0
Underweight, 10% or more	30.3	29.4
Average weight	48.6	43.9
Overweight, 10-24%	14.8	15.1
Overweight, 25% or more	5.3	11.5

MATERIAL

We investigated the frequency of obesity in essential hypertension, angina pectoris, coronary insufficiency, and coronary occlusion among unselected private patients, in all of whom the height and weight were known (table 2). They were grouped as underweight (10% or more), average weight, overweight (10 to 24% above average), and obese (25% or more above average) according to the standard weight tables established in 1912 and those employed generally. The frequency of each weight group in our cases was then compared, according to age, with similar weight classifications determined in the series mentioned above.[6] The ages of the patients in

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Mr. Herbert H. Marks, the Metropolitan Life Insurance Company, New York, gave statistical assistance, and Miss Iris Kanner helped collect the data.

the group serving as controls ranged between 20 and 64 years, and 90% of our patients also fell within these limits.

Obesity and Coronary Disease.—There is considerable difference of opinion concerning the relationship between obesity and coronary disease. Some authors have stated that coronary artery disease and occlusion are commoner in those who are overweight.[8] Among Army officers, cardiovascular renal disease was found to develop much more frequently in those who were overweight.[9] In Wilens' postmortem material,[10] advanced coronary artery disease was much more frequent among the obese and was found in only 6.7% of those whose nutritional status was poor. Yater and associates [11] and Gertler and co-workers,[12] however, were unable to establish an etiological relationship between obesity and coronary artery disease in young patients. Gertler and co-workers, in somatotype studies, found that coronary disease and occlusion are apt to occur in persons of mesomorphic habitus, i. e., those with well-developed musculature, rather than in the obese.

TABLE 2.—*Weight of Patients with Angina Pectoris, Coronary Insufficiency, Hypertension, and Coronary Occlusion with Relation to Standard Weight*

Disease According to Weight Group	Men, % of Total		Women, % of Total	
	Sample	Control	Sample	Control
Angina pectoris				
Underweight	12.0	30.3	29.0	29.4
Average weight	49.0	48.6	32.0	43.9
Overweight	32.0	14.8	15.0	15.1
Obese	7.0	5.3	4.0	11.5
Total cases, men	100		...	
Total cases, women	...		100	
Coronary insufficiency				
Underweight	4.4	30.3	11.5	29.4
Average weight	55.6	48.6	61.8	43.9
Overweight	33.6	14.8	19.2	15.1
Obese	5.4	5.3	7.5	11.5
Total cases, men	113		...	
Total cases, women	...		26	
Hypertension				
Underweight	10.3	30.3	17.6	29.4
Average weight	51.5	48.6	51.0	43.9
Overweight	32.2	14.8	15.7	15.1
Obese	6.0	5.3	15.7	11.5
Total cases, men	118		...	
Total cases, women	...		51	
Coronary occlusion				
Underweight	8.0	30.3		
Average weight	43.0	48.6		
Overweight	33.0	14.8		
Obese	16.0	5.3		
Total cases, men	100			

We divided our patients with coronary disease into three groups; those with angina pectoris, acute coronary insufficiency, or acute coronary occlusion. Episodes of coronary insufficiency are severer than angina pectoris and often simulate coronary occlusion.[13] Coronary insufficiency, however, differs from coronary occlusion in cause, pathological changes, electrocardiographic findings, and treatment. Coronary insufficiency occurs when the coronary flow is inadequate to meet the demands of the heart muscle and is, therefore, induced by conditions increasing the work of the heart, reducing the coronary flow, or diminishing the oxygen content of the blood. There is no acute occlusion of a coronary artery. Focal areas of necrosis may appear in the subendocardial area. Treatment is directed against the precipitating condition, e. g., repeated transfusions are given for sudden hemorrhage. Coronary occlusion, on the other hand, occurs spontaneously, and its therapy is symptomatic.[14]

Angina Pectoris.—There were 100 men and 100 women with angina pectoris, but none had suffered a severe acute episode necessitating bed rest. There was a significant increase in the proportion of overweight men as compared with the controls, the ratio being 39 to 20 (table 2). On the other hand, the proportion of obese women with angina pectoris was even less than in the control group.

Coronary Insufficiency.—One hundred thirty-nine patients, of whom 113 were men, had experienced one or more attacks of acute coronary insufficiency, e. g., pain associated with RS-T depression and T-wave changes in the electrocardiogram that disappeared after a number of days. This type of change indicated ischemia or necrosis of the subendocardial area without acute thrombosis of a coronary artery. As in angina pectoris, the proportion of overweight men with acute coronary insufficiency was almost double that in the control group the ratio being 39 to 20% (table 2). No difference was found in the women.

Coronary Occlusion.—In taking the histories of patients with previous coronary occlusion, those with large Q-waves and RS-T elevation in their electrocardiograms, it was found that the vast majority of them had been placed on strict diets after the attack and that they had lost a great deal of weight. As a result, they showed the same frequency of obesity as did the controls; therefore, the weight prior to the attack was individually determined in 100 men. They showed a definite increase in frequency of overweight, 33 to 14.8%, and of obesity, 16 to 5.3%, as compared to the normal group (table 2). Weights were obtained in an insufficient number of women for statistical purposes.

Essential Hypertension and Obesity.—Numerous statistical studies have conclusively shown that the blood pressure, particularly the systolic, is significantly higher in normal obese persons than in those who are of average weight or underweight.[15] This has recently been shown to be true also in the rat.[16] Similarly, hypertension occurs more frequently in the obese.[17] In 1,332 healthy men, Huber [10b] found that 18% of those who were overweight had high blood pressure while almost half of those who were 10% underweight had a subnormal blood pressure. Levy and his associates [9b] noted that sustained hypertension developed in obese Army officers two and one-half times as frequently as in men not overweight. Furthermore, it has been shown that a reduction in weight is often followed by a fall in blood pressure in both normal and hypertensive persons.[18] A loss of 10 lb. (4.5 kg.) was found to cause an average drop of 15 mm. Hg in the systolic pressure and 10 mm. Hg in the diastolic pressure.[18b] Moschcowitz [18c] has suggested that in obesity hypertension is a compensatory effect to meet the increased burden on the heart, which may not keep pace in size and weight with the growth of the body. This theory would account for the drop in blood pressure after loss of weight and for the tendency of thin persons to have low blood pressure.

Among the 1,000 patients studied, there were 169 with hypertension, according to the recent criteria of Master, Dublin, and Marks.[6] One hundred eighteen were men and 51 were women. Among the men, overweight

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195

was decidedly more frequent than it was among the general population, the ratio being 32.2% to 14.8% (table 2). The percentage of distinctly obese men, those whose weight was 25% or more above the standard, however, was the same in the hypertensive and control groups, 6 to 5.3%. There was no significant difference in the frequency of obesity among the hypertensive women and the control group; the figures were 31.4 and 26.6% (table 2).

COMMENT

The literature and our own findings, in this and previous investigations, clearly indicate the importance of avoiding obesity in cardiovascular disease. In patients who are overweight, the mortality rate is twice that of average or underweight patients.[19] Obesity increases the basic work of the heart and thus places a strain on it.

It is apparent that hypertension, as defined by the new criteria, is found more commonly in obese men than in those who are of average weight or who are underweight, but the exact relationship between hypertension and obesity remains obscure. There is no definite evidence that the obesity is causally related to the hypertension. It may be that the factors resulting in hypertension also produce obesity, e. g., emotional influences, faulty metabolism, or a hormone disturbance. It is questionable that obesity is ever the sole factor in the development of hypertension, for it is quite common to find a normal blood pressure in the presence of excessive obesity. There is no doubt, however, that overweight is detrimental when the blood pressure is already elevated and that improvement usually follows a loss of weight.

Overweight is also much commoner among men who suffer from coronary disease than in the control groups.[10] This fact does not necessarily prove a causal relationship; other suggestive evidence has been presented by Gofman and Jones.[20] They found the S_f 35-100 particles in the blood were moderately related to obesity and that the S_f 12-20 particles showed a lesser, but yet significant, relation to obesity. Since these particles are increased in patients with coronary sclerosis, they concluded that obesity was related to this disease.

In cardiac disease, obesity predisposes the patient to anginal pain and congestive failure. It has been shown that obesity increases oxygen consumption, cardiac rate, blood pressure, and cardiac work. It reduces work tolerance, cardiac reserve, and vital capacity after exercise.[1] Conversely, loss of weight is usually very beneficial to obese patients with cardiac disease; their cardiac reserve is increased and their symptoms may disappear for long periods.[1] It is significant that we found a low incidence of overweight among patients who had made a long-lasting, complete functional recovery from coronary occlusion and insufficiency.[21] In these patients, the avoidance of overweight probably was a factor in the complete functional recovery from severe acute episodes of coronary disease.

A surprising finding in our cases was the failure of the women to show a greater proportion of overweight than the controls. Although this observation is being investigated in a large number of women before it is accepted, it suggests that in women, unlike men, the development of hypertension and coronary disease does not depend on obesity. The reason for this possible difference between the sexes is not obvious. We have mentioned one observation that is of possible significance, the proportion of obesity in the control group was much higher in the women than in the men.

SUMMARY AND CONCLUSIONS

The relation of obesity to heart disease is reviewed. The harmful influence of obesity on the normal and on the diseased heart is well established. Persons with heart disease or hypertension who are obese have a much higher mortality rate than those who are of average weight or below.

New standards of weight and of hypertension for the general population were employed in this investigation. These recently established limits are more representative of the present population than the figures previously employed. The frequency of obesity in patients with heart disease in private practice was ascertained. There was a definite increase in the relative frequency of overweight in men with coronary disease, including angina pectoris, coronary insufficiency, and coronary occlusion. Obesity is a strain on the heart and is capable of aggravating coronary disease. On the basis of the new criteria of hypertension, overweight occurred more frequently among men with hypertension than among the general population.

In women, obesity was not more frequent than in the normal population. This observation is being investigated in a large series of women. The reason for the possible difference between the sexes is not obvious It may be significant that the proportion of obesity in the control population is higher in women than in men. The development of coronary disease and hypertension in women may not be influenced by obesity.

Although obesity occurs more commonly in patients with hypertension or coronary disease, no definite conclusion concerning the etiological relationship between obesity and these diseases can be drawn. The reports in the literature and our own observations, however, clearly indicate the importance of avoiding obesity in cardiovascular disease.

Fifth Ave. at 100th St. (29) (Dr. Master).

Widowhood.—Where husband and wife are the same age, the chances that the wife will outlive her husband are 60 to 100, but they rise to 70 where the husband is 5 years older, and to almost 80 if he is her senior by 10 years. Widowhood is practically a certainty for wives 20 or more years younger than their husband, the chances in such extreme instances being of the order of 90 in 100. Only if the wife is at least 5 years older than her husband are the odds against her being widowed. The median age at which wives enter widowhood is about 56 years. However, a significant number are much younger when their family life is disrupted by the death of the husband; almost one-quarter of the new widows each year are under age 45. Although widowhood has been postponed to the older ages, most women still have many years of life ahead of them after their husband dies. . . . Three quarters of the women who are widowed at age 50 will live 20 years longer; that many years of life also remain for nine out of every 10 wives bereft of their mates before age 40. Even at age 65, fully one half of the widows can expect to survive for 15 years and almost one third for 20 years.—Metropolitan Life Insurance Company, Widowhood and Its Duration, *Statistical Bulletin*, September, 1953.

EVALUATION OF ADRENAL RESECTION AND SYMPATHECTOMY IN NINETY-NINE PERSONS WITH HYPERTENSION

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This study was begun in March, 1950, after a subtotal adrenalectomy was completed in a patient in whom severe hypertension had recurred one year after a thoracolumbar sympathectomy was performed. As our series of patients increased, we reported encouraging results [1] after employing various types of sympathectomy and various degrees of adrenal resection. This analysis includes 99 such patients followed for from 1 to 37 months after operation. It is our present feeling that sympathectomy combined with adrenalectomy is more effective than either sympathectomy or adrenalectomy alone. We feel, however, that further observations are required to prove or disprove this impression.

INDICATIONS AND CONTRAINDICATIONS

We have required that all three of the following indications be present before operation is attempted. 1. Average diastolic blood pressures should be 120 mm. Hg or more. 2. There should be failure to respond to intensive medical therapy. 3. There should be evidence of progressive damage to the heart, kidneys, brain, or eyes. From our experience to date, any one of the following factors is a contraindication to operation: (1) poor renal function, with excretion of less than 20% of phenolsulfonphthalein 15 minutes after intravenous injection, and/or a blood urea nitrogen of over 20 mg. per 100 cc., (2) convalescence from a stroke or coronary occlusion for less than six months, (3) age above 55 years, and (4) inability of the patient to cooperate in a careful postoperative program because of intellectual deficit or emotional instability.

From the Edward B. Robinette Foundation, Medical Clinic, and the Surgical Service of the Hospital of the University of Pennsylvania.

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Misses Nelly Jane Keffer, Janet Merrill, and Henrietta Brandt made daily blood pressure readings when patients were in the hospital and on return visits. They helped prepare some of the tables.

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The Upjohn Company, Kalamazoo, Mich., supplied the adrenal cortical extract used in this study; Merck & Company, Inc., Rahway, N. J., the aqueous suspension and tablets of Cortone; and Ciba Pharmaceutical Products, Inc., Summit, N. J., and Schering Company, Bloomfield, N. J., the DCA for both oral and parenteral use.

1. (*a*) Lukens, F. D. W., and others: Observations on Subtotal Adrenalectomy in Hypertension, Tr. Am. Clin. Climatol. A. **62**: 229, 1950. Wolferth, C. C., and others: Observations on the Results of Subtotal Adrenalectomy in the Treatment of Severe, Otherwise Intractable Hypertension and Their Bearing on the Mechanism by Which Hypertension Is Maintained, Ann. Int. Med. **35**: 8 (July) 1951. Zintel, H. A., and others: Ninety-five Per Cent Subtotal Adrenalectomy for Essential Hypertension, Surg. Forum, Proc. Clin. Cong. Am. Coll. Surg. 1950, p. 556. (*b*) Wolferth, C. C., and others: Effects of Subtotal Adrenalectomy Alone and Combined with Sympathectomy upon the Blood Pressure Levels and Complications of Severe Arterial Hypertension, Bull. New York Acad. Med. **29**: 115 (Feb.) 1953. (*c*) Jeffers, W. A., and others: The Clinical Course, Following Adrenal Resection and Sympathectomy, of 82 Patients with Severe Hypertension, Ann. Int. Med. **39**: 254 (Aug.) 1953.

TYPES OF OPERATIONS PERFORMED

The Peet sympathectomy and the modifications of the Adson and Smithwick procedures that one of us (H. A. Z.) has performed in these patients are illustrated in figure 1. The modified Adson sympathectomy includes removal of the 12th thoracic and the upper two lumbar sympathetic ganglions, together with interruption of the three splanchnic nerves. The modified Smithwick sympathectomy includes removal of the lower six or seven thoracic ganglions and the three lumbar ganglions, together with excision of the three splanchnic nerves above the diaphragm. With but few exceptions, operations were performed through a retroperitoneal incision in two stages about 10 days apart.

TABLE 1.—*Types of Operations Performed in Ninety-Nine Patients*

Subtotal adrenalectomy	
Alone (SA)	11
With Adson sympathectomy (SA-ADN)	49
With Smithwick sympathectomy (SA-SMK)	8
With Peet sympathectomy (SA-PEET)	1
With Adson sympathectomy on one side and Smithwick on the other (SA-MIXT)	4
Total adrenalectomy	
Alone (TA)	2
With Adson sympathectomy (TA-ADN)	21
With Smithwick sympathectomy (TA-SMK)	3
Total	99

After observing the results of various types of adrenal resection in the first 10 patients, it was found that sufficient adrenal tissue had been removed when a fragment equivalent to a 5 or 6 mm. cube remained adjacent to the adrenal vein on the left side and when all of the right adrenal gland had been removed. This is our meaning of subtotal adrenalectomy with respect to most of the patients who had combined subtotal adrenal resection and sympathectomy. The various types of operations performed on the 99 patients of this series are listed in table 1.

A relatively large number of patients has been followed for not more than six months, and few have been followed for as long as 37 months. The duration of postoperative observation at six month intervals is shown in table 2.

METHOD OF EVALUATION

Our classification of the status of patients after operation included four groups—A, excellent, B, fair, C, poor, and D, failure. Group A included persons with blood pressures less than 150/100 mm. Hg both lying and standing. Group B included those with blood pressures more than 150/100 lying but less than 150/100 standing. Group C included patients in whom the blood pressure was essentially unchanged after operation. Signs and

symptoms were, however, improved in patients in this group. Group D consisted of patients in whom the blood pressure, signs, and symptoms were unchanged after operation. Careful and repeated postural blood pressure tests [2] are essential for this classification. In addition, repeated clinical examinations and special laboratory tests have been performed before and after operation.

TABLE 2.—*Duration of Follow-Up After Operation Among Ninety-Nine Patients*

Months	No. of Patients
0- 6	41
7-12	13
13-18	22
19-24	6
25-30	12
31-37	5

RESULTS

Figure 2 shows the results now apparent in relation to various combinations of sympathectomy and adrenalectomy and to adrenalectomy alone. Patients who died, even though they may have shown temporary improvement, are included in this analysis only as mortalities. It is evident that we have concentrated on testing the effect of an Adson sympathectomy combined with either total or subtotal adrenalectomy. We have also classified our patients prior to operation according to the semiquantitative grading system devised by Smithwick.[3] Its usefulness is suggested (table 3) by the relatively poor results among those with the poorest prognosis (Smithwick group 4); on the other hand, it is of interest that 6 of 52 patients,

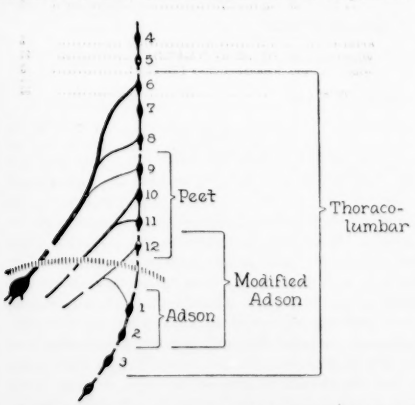

Fig. 1.—Types of sympathectomy commonly employed for the treatment of hypertension. The so-called total sympathectomy of Grimson is not included in this diagram. (Reproduced with permission from the *Annals of Internal Medicine*, August, 1953.)

initially in Smithwick group 4, have shown an excellent response up to this time.

Since 52, or over half, of our patients fell into Smithwick group 4, the loss of 24 of them within 37 months after operation was not unexpected. An operative mortality of only 8%, within a month after operation, seems creditable. The usual cause of death was a cerebral vascular accident or a coronary occlusion. Only one patient died from adrenal insufficiency.

Table 4 shows the percentile incidence of improvement with respect to heart size (45%), ocular fundi (45%), electrocardiographic abnormalities (41%). As improvement we included any persistent diminution in the heart's

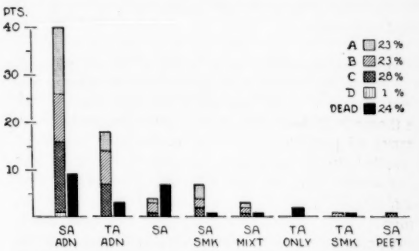

Fig. 2.—Types of operations performed and results of those procedures in 99 patients with severe hypertension.

frontal area, any persistent decrease in the grade of retinopathy, and any progressive tendency for abnormalities of the QRS and T-waves to revert toward normal. Of 56 patients adequately studied, 10 showed no albuminuria and 25 no cylindruria before or after operation. In 10

TABLE 3.—*Classification of Postoperative Result in Relation to Preoperative Smithwick Group*

Smithwick Group	Our Group A	B	C	D	Dead
1	0	0	0	0	0
2	12	7	7	1	2 (7%)
3	5	8	3	0	2 (11%)
4	6	8	18	0	20 (38%)
Totals	23	23	28	1	24

TABLE 4.—*Incidence of Improvement in Heart Size, Retinopathy, and Electrocardiographic Abnormalities in Seventy-Five Surviving Patients*

Operative Procedure	No. of Patients	Heart Size, %	Retinopathy, %	Electrocardiographic Abnormalities, %
SA	4	50	25	75
SA-SMK	7	86	100	43
SA-ADN	40	43	50	43
SA-PEET	1	100	100	0
SA-MIXT	3	67	0	100
TA-ADN	18	22	22	22
TA-SMK	2	100	50	50
Total or average	75	45	45	41

albuminuria and in 6 cylindruria was present in the same degree before and after operation. In six albuminuria and in eight cylindruria was more abnormal after than before operation. In 30 albuminuria and in 17 cylindruria was less abnormal after operation than before. Of the 30 showing less albuminuria, only 7 had a change from 3 plus

2. Jeffers, W. A.; Sheiman, S. C., and O'Brasky, G. H.: Use of a Simple Postural Test in Neurocirculatory Asthenia, Am. J. M. Sc. 210: 511 (Oct.) 1945.

3. Smithwick, R. H.: The Effect of Sympathectomy upon the Mortality and Survival Rates of Patients with Hypertensive Cardiovascular Disease, in Hypertension, edited by E. T. Bell, Minneapolis, University of Minnesota Press, 1951, p. 429.

to 1 plus or less. Fourteen had only a trace of albumin prior to operation, with none detected after operation. Improvement with respect to cylindruria was observed less frequently. A sufficient number of urinalyses were not available to warrant similar comparison in the remaining 43 patients. There has not been, to date, consistent evidence of improvement in renal function, as measured by repeated phenolsulfonphthalein tests or by special clearance studies.

TABLE 5.—*Postoperative Course of Forty Patients Who Had Paroxysmal Dyspnea and Congestive Heart Failure Before Operation*

		Postoperative				
					Dead	
	Preoperative	A	B	C	Heart Failure	Other Causes
Paroxysmal dyspnea...	19	5	5	4	0	5
Frank heart failure....	21	3	4	7	0	7

The clinical course of patients who had angina pectoris or a coronary occlusion prior to operation was also studied. All of those with only mild angina were relieved of this symptom. Patients with severer coronary disease have shown at best a variable course. Of eight patients with frequent attacks of angina preoperatively, three were relieved of angina, three survived coronary occlusions, and one died from a coronary occlusion. Five patients, in whom angina had not been present preoperatively, died from coronary occlusions after operation.

The fate of patients who showed congestive heart failure or paroxysmal dyspnea prior to operation is shown in table 5. It became apparent early in our study [4] that a tendency toward heart failure was apt to be corrected after this operation, and this has continued to be a striking phenomenon.

It appears proper to continue to operate on patients who have had a good recovery from cerebral vascular accidents for at least six months. Table 6 indicates the course of patients with evident cerebral vascular damage.

REPLACEMENT THERAPY

Our observations to date indicate that a favorable response to adrenal resection, either alone or combined with sympathectomy, is infrequent unless sufficient

TABLE 6.—*Postoperative Course of Nineteen Patients Who Had Preoperative Cerebral Vascular Damage*

		Postoperative						
						Dead		
	Preoperative	A	B	C	D	Stroke	Other Causes
Without residuals.....	9	2	4	1	1	1	0
With residuals.....	10	1	1	4	0	3	1

adrenal tissue has been removed to render the patient susceptible to adrenal insufficiency when cortical replacement therapy and salt are withdrawn. Hills and co-workers [5] have made a quantitative estimation of residual adrenal function in 10 patients after operation. They used a method developed for the purpose.

Table 7 gives a schedule of the amounts of cortisone, desoxycorticosterone (DCA), and sodium chloride used in connection with operation. During the first month after operations that include extensive adrenal resection, a liberal amount of cortical replacement therapy has been given, if blood pressures are not higher than 180/100 mm. Hg or there is the usual marked fall in blood pressure on standing. This may include cortisone, 37.5 to 50 mg in divided dosage daily, desoxycorticosterone, 2 mg buccally, and enteric-coated tablets of sodium chloride, 3 to 6 gm. daily. Later, the dosage of cortisone, salt, and desoxycorticosterone is diminished in each patient to achieve an optimal level of blood pressure, while avoiding anorexia, nausea, or hyperkalemia. With the onset of warm weather, an increase in the amount of replacement therapy is necessary. Patients are instructed to report anorexia or nausea promptly to their physicians and to seek medical care without delay in the event of a respiratory infection or other febrile episode, in order that replacement therapy can be increased temporarily.

TABLE 7.—*Schedule of Replacement Therapy Used in Connection with Second Operation of Total or Subtotal Adrenalectomy*

	Cortisone	Desoxycorticosterone (DCA)	Other
Day of operation	50 mg. intramuscularly just before operation; repeat 6 hr. after operation	0	2,000 cc. 5% dextrose in water slowly, 1,000 cc. 5% dextrose in sodium chloride solution slowly, or 1,000 cc blood
First postoperative day	50 mg. intramuscularly every 12 hr.	0	As above
Second and third postoperative day	25 mg. orally every 8 hr.	2 mg. bucally	1-2 gm. orally after each meal
Fourth postoperative day	25 mg. orally every 12 hr.	As above	As above

COMMENT

The operative approach for the treatment of severe hypertension that we have chosen to follow is an attempt to combine the possible benefits of sympathectomy of the Adson or Smithwick type with subtotal or total adrenalectomy. The Adson sympathectomy, combined with adrenal resection and performed in two separate stages, has been well tolerated by most patients who have had adequate preservation of renal function. Their convalescence has been marked by its ease and freedom from the pulmonary complications and prolonged backaches that may follow thoracolumbar sympathectomy. It will require further observation to establish whether, or under what circumstances, this type of operation will prove superior in the long run to (1) thoracolumbar sympathectomy, (2) thoracolumbar sympathectomy plus subtotal or total adrenalectomy, or (3) total adrenalectomy alone.[6]

Operations of this sort cannot be attempted without a well-integrated medical and surgical team that is prepared to deal not only with all surgical complications but with any of the manifestations of severe hypertensive cardiovascular disease or adrenal insufficiency. In the case of each patient, a prolonged and careful follow-up is obligatory. A member of the team must be on call at all times,

4. Wolferth, C. C., and others: Effects of Subtotal Adrenalectomy With or Without Sympathectomy upon the Course of Congestive Heart Failure, read before the American Heart Association, Atlantic City, N. J., April 11, 1953. Wolferth and others.[1b]

5. Hills, A. G., and others: Quantitative Evaluation of Primary Adrenal Cortical Function in Man, Am. J. Med., to be published.

6. Thorn, G. W., and others: Clinical Studies in Bilateral Complete Adrenalectomy in Patients with Severe Hypertensive Vascular Disease, Ann. Int. Med. 37: 972 (Nov.) 1952.

and he must be prepared to treat acute adrenal insufficiency or any other emergency. We have encountered to date no greater difficulty in managing patients after total adrenalectomy than after subtotal adrenalectomy. Our patients do not appear to lack energy and vigor for their full work loads unless they have cardiovascular complications. The only symptom frequently mentioned is a mild intolerance to cold.

SUMMARY AND CONCLUSIONS

The results of various degrees of adrenal resection with and without various types of sympathectomy in 99 patients with severe hypertension are reported. To be eligible for operation patients fulfilled all of the following qualifications. They had (*a*) an average diastolic blood pressure of 120 mm. Hg or more, (*b*) lack of response to intensive medical therapy, and (*c*) evidences of progressive vascular damage. Tentative contraindications include any one of the following factors: (*a*) poor renal function, (*b*) less than six months' convalescence from a stroke or coronary occlusion, (*c*) age over 55 years, or (*d*) inability, for any reason, to cooperate in taking adrenal cortical replacement therapy.

The majority (70) of patients were subjected to an Adson sympathectomy, plus either subtotal or total adrenalectomy. In the case of subtotal adrenalectomy, all adrenal tissue was removed except a piece about 6 mm. in diameter adjacent to the adrenal vein on the left side. Operations were performed through a retroperitoneal incision and in two stages about 10 days apart. Further observation must be made to determine whether the Adson sympathectomy, combined with total or subtotal adrenalectomy, is more or less effective than thoracolumbar sympathectomy or total adrenalectomy without sympathectomy.

During the period of postoperative observation of the 99 patients, 23% showed an excellent response, 23% a fair response, and 30% a poor response; 24% died. Only one patient died from uncomplicated adrenal insufficiency; the usual cause of death was a stroke or a coronary occlusion. Patients with paroxysmal dyspnea or congestive heart failure prior to operation showed the most striking improvement. This appears to be primarily the result of extensive resections of adrenal cortex. Most of those subjected to subtotal adrenalectomy required adrenal cortical replacement therapy after operation. Objective changes have been observed in the heart size, retinopathy, and electrocardiographic findings. Precautions necessary for the successful management of patients subjected to these procedures are discussed.

36th and Spruce st. (Dr. Jeffers).

PROBLEM OF THE GASTRIC ULCER REVIEWED

STUDY OF ONE THOUSAND CASES

Frances H. Smith, M.D., Russell S. Boles Jr., M.D.
and
Sara M. Jordan, M.D., Boston

The problem of gastric ulcer continues to be a subject of controversy because of the association of this disease with cancer of the stomach. Since surgeons and gastroenterologists are so often confronted with the grim and frustrating circumstances that surround the diagnosis and treatment of gastric cancer, it is natural that any lesion of the stomach should be considered potentially malignant. Such fear is indeed justified if it breeds a vigilance that may result in the early detection of cancer; however, it must not be forgotten that benign ulcers of the stomach with potentiality of complete healing do occur.

Ulcerating lesions of the stomach fall into one of two categories: (1) ulceration in an infiltrating lesion, grossly recognized as malignant, and (2) ulceration with an appearance of peptic ulcer. The disposition of the first group is, of course, to immediate surgery, with the hope that operation is possible and the condition is still without metastatic involvement. In the second group, the peptic ulcer that may be benign can be finally diagnosed as such only when histological examination or adequate clinical evidence of healing furnishes proof of this diagnosis. And it is over this point that there is controversy. Some physicians believe that excision of the lesion and histological examination are the only proof of diagnosis and the only guarantee of safety, while others believe that intensive treatment under observation and inspection of healing is adequate proof that the lesion is a benign ulcer, which, when healed, carries no potential danger of malignancy.

CASE MATERIAL

This study deals with 1,000 patients who had gastric lesions of this second group that, when first seen, could reasonably be regarded as benign ulcers. It is our intention to indicate by statistics the fate of these 1,000 patients. Most of the cases previously reported [1] by two of us (1948) are included. In the present study, 578 patients were operated on and 422 had medical treatment alone. There were 912 (91.2%) patients with benign gastric ulcer and 88 (8.8%) with malignant ulcer. In the group of 912 patients, 635 (70%) were male and 277 (30%) were female. Of the 88 patients with malignant ulcer, 64 (73%) were male and 24 (27%), female.

The ages of the patients included in this study ranged from 10 to 89 years. Their distribution followed the expected pattern since the ages of the largest number of patients with benign and malignant ulcers, both surgically and medically treated, fell in the sixth decade. In the

From the Department of Gastroenterology of the Lahey Clinic.

Read before the Section on Gastroenterology and Proctology at the 102nd Annual Meeting of the American Medical Association, New York, June 2, 1953.

1. Smith, F. H., and Jordan, S. M.: Gastric Ulcer: Study of 600 Cases, Gastroenterology **11**: 575-597 (Nov.) 1948.

surgically treated group, the ages of five patients with benign ulcers and four with malignant ulcers were in the third decade. In this group, there was one patient with benign ulcer whose age was in the ninth decade. Among the patients who had medical treatment only, the ages of three with benign ulcers were in the second decade and of six in the ninth decade.

Gastric resection was performed in 474 patients with benign gastric ulcer, and in 7 of these all of the stomach was removed. Gastric resection was performed on 60 patients with malignant ulcers, and nine total gastrectomies were performed in this group. In 23 patients with benign ulcers and 21 patients with malignant ulcers, other surgical procedures, including exploratory laparotomy, repair of perforation, gastroenterostomy, and ligation of a bleeding artery, were used. There were 415 patients with benign gastric ulcers and 7 patients with malignant gastric ulcers who had medical treatment only. Of 578 patients who had surgical intervention, 541 were operated on within five years after their first admission, and of this group 512 had gastric resection. Thirty-seven patients, of whom 22 had resections, were operated on later than five years after their first admission. Two hundred twenty-four patients were treated medically and

TABLE 1.—*X-ray Location of Gastric Ulcer in 963 Patients*

	Benign		Malignant	
	No.	%	No.	%
Fundus	45	5.2	5	6.0
Media	518	58.9	47	55.9
Antrum	96	10.9	13	15.5
Prepylorus	157	17.8	14	16.6
Pylorus	63	7.2	5	6.0
Total	879	100	84	100

followed for five years or less, and 198 patients were treated medically and followed for more than five years.

It is striking in this study that there was no significant difference in the weight loss in the groups with benign and malignant ulcer; 35% of the patients with malignant ulcer and 37% with benign had lost no weight. Approximately 42% of the patients with benign or malignant ulcer lost 11 lb. (5 kg.) or more, and marked loss of weight (20 lb. [9.1 kg.] or more) was found in about 19% in both groups. The deduction from these statistics was, therefore, that although loss of weight occurred with malignant gastric ulcer in 65% of the patients it was of questionable significance as a point of differentiation between a benign and a malignant ulcer since it also occurred with benign ulcer in 62% of the patients.

GASTRIC ANALYSIS

Since histamine stimulation was not used in most of the 867 patients who had gastric analysis, the results may be considered to represent functional secretion. In the group with malignant ulcer, the percentage of patients with achlorhydria (8.8%) was only 3% less than that of patients with hyperchlorhydria (11.8%), and the largest percentage (57.3%) was in the normal range of acidity. In the group with benign ulcer, the largest number of patients was in the normal range, but 5.1% had achlorhydria.

X-RAY EXAMINATION AND GASTROSCOPY

Although malignant ulcers are found to occur anywhere in the stomach, ulcers in certain areas, notably the prepylorus and the greater curvature, are generally considered to have a much greater incidence of malignancy. In our present study, 22.6% of benign ulcers and 28.1% of malignant ulcers were located in the prepylorus on pathological examination. These figures differ from those that would have been derived from roentgenologic study alone, as the following discussion shows.

In 37 patients of the series of 1,000 cases the diagnosis of gastric ulcer was not proved or reported preoperatively, chiefly because operation was done for acute abdominal conditions or obstruction. Of the 963 patients who had x-ray examination, 515 (451 with benign ulcer and 64 with malignant) were operatod on and the actual location was reported by the pathologist (table 1). Roentgenograms showed that the benign ulcers of 97 patients were in the prepylorus and of 44 patients were in the pylorus. Of the 97 prepyloric lesions, 11 were found by the pathologist to be pyloric, which made 86 prepyloric and 55 pyloric lesions. Of the 44 ulcers reported to be in the pylorus by roentgenograms (actually 55), 16 were found by the pathologist to be prepyloric, which left 39 pyloric lesions and 102 prepyloric lesions.

Since the lesions in 451 patients who had resection performed were benign and 102 of these were proved by the pathologist to be prepyloric, the percentage of proved benign prepyloric ulcers was 22.6. In the group with malignant ulcer, 14 patients had lesions diagnosed by x-ray examination as prepyloric but one lesion was actually pyloric. Five lesions were called pyloric but were demonstrated to be prepyloric, so that in 18 (28.1%) of the 64 patients with malignant ulcer the lesion was actually prepyloric. Seventeen of the 451 benign gastric lesions that were resected were shown in roentgenograms to be on the greater curvature, but only 4 were thus described by the pathologist. It is interesting to note that the percentage of benign lesions of the media was 48 and the percentage of the malignant lesions in that area was 52. Eight of 64 malignant lesions operated on were shown in roentgenograms to be on the greater curvature. These were confirmed in the pathological examination.

By means of roentgenograms coexistent duodenal deformities were reported in 19.7% (173 of 879 patients) with benign gastric ulcer and in 20.2% (17 of 84) with malignant ulcer. These findings suggested that the demonstration of a duodenal deformity by means of roentgenograms was of no help preoperatively in differentiating a benign from a malignant ulcer. Hourglass deformity was present in 4.3% (38 of 879 patients) with benign gastric ulcer and 7.1% (6 of 84 patients) with malignant ulcer, a ratio of 6.33 to 1. Although the percentage difference between malignant and benign hourglass deformity was considerable, the total number (44) in both groups was too small for accurate deduction. In the group of patients with benign gastric ulcer, 2.4% (21 of 879 patients) had multiple ulcers. Twenty of these patients had resection and pathological diagnosis and/or surgical confirmation. In one patient the diagnosis was made with roentgenograms alone. Of the group

with malignant ulcer, 1.2% (1 of 84 patients) had more than one gastric ulcer as diagnosed with roentgenograms alone.

In 5.2% of the 1,000 patients studied, gastroscopy was performed. This report includes only those cases in which x-ray visualization and symptoms were highly suggestive of malignancy and in which gastroscopic visualization of the lesion was possible. The gastroscopic diagnosis was verified by pathological examination in 20 patients with benign ulcer and 13 with malignant ulcer.

TABLE 2.—*Reasons for Operation on 578 Patients with Gastric Ulcer*

	Benign		Malignant	
	No.	%	No.	%
Suspected malignancy	201	40.4	43	53.1
Intractability *	103	20.7	15	18.5
Recurrence	81	16.3	15	18.5
Acute hemorrhage	39	7.8	2	2.5
Multiple hemorrhages	14	2.8	1	1.2
Obstruction	50	10.1	4	4.9
Perforation	9	1.8	1	1.2
Total	497		81	

* By intractability is meant persistence of symptoms and x-ray evidence.

The pathological findings were at variance with the gastroscopic diagnosis in 5 of the benign and 14 of the malignant ulcers.

RESULTS IN PATIENTS WITH BENIGN ULCER

Although suspected malignancy, recurrence, and intractability were separately listed as indications for operation, in actual fact these categories might overlap, since malignancy was usually suspected when an ulcer was intractable or recurrent. Suspected malignancy was the stated reason for operation in 40.4% of the patients with benign resected ulcer and in 53.1% with malignant ulcer. Recurrence was considered an indication for resection, and table 2 shows that, of the 497 patients who were operated on for benign ulcer, 16.3% had recurrent benign lesions and, of 81 patients with malignant ulcer, 18.5% had recurrent lesions. Perforation, hemorrhage, and obstruction were of higher incidence in the group with benign ulcer than in the group with malignant ulcer.

The clinical evaluation of results as shown in tables 3 and 4 was based on the presence or absence of the following criteria: (1) distress; (2) nausea and vomiting; (3) recurrent ulcer as shown in roentgenogram; (4) hemorrhage; (5) weakness and inability to work and in the surgical group dumping syndrome and persistent diarrhea. The reports were based on clinical records and replies to questionnaires and show results that indicate little difference of morbidity in the surgically and medically treated groups.

RESULTS IN PATIENTS WITH MALIGNANT ULCER

There were 88 patients with malignant ulcer in this study. Sixty had resection; 21 who could not have resection underwent other surgical procedures, such as gastroenterostomy, suture of perforation, ligation of an artery, or exploratory laparotomy. In 30 patients the operation was performed within a week after the time the patient was first seen; 21 patients were operated on within a month; 8 patients were operated on from one to two months after their first admission, 6 of these in the years between 1935 and 1945 and 2 in 1951. Four patients had operations within two to four months, three between the years 1938 and 1945, and one in 1949. Five patients were operated on between four months and one year after their first admission, four between the years 1931 and 1944, and one in 1951. Ten patients were not operated on until one to five years after their first admission, nine between the years 1934 and 1946 and one in 1948. Three patients seen between the years 1931 and 1943 were not operated on until five years after their first admission. After 1946, only five patients were treated longer than one month before resection, although in the preceding years 25 patients were maintained beyond one month with medical treatment. Among all the patients maintained beyond one month with medical treatment, 15 had recurrences at intervals of six months to seven years after admission and 5 between one and two years after admission.

Seven patients who were not operated on died with malignant ulcer. The first patient was originally seen in 1924, and a diagnosis of benign ulcer was made. It healed completely under medical management. The patient had no recurrence for 22 years, but at autopsy, 23 years later, carcinoma in situ was found. The second patient, first seen in 1938, could not be treated surgically because of concomitant disease. He died in 1941. The third patient was first seen in 1940; surgery was advised but refused. He died in 1941. The fourth patient was originally seen in 1940 and was followed for nine months at frequent intervals, with clinical and x-ray evidence of complete healing. At autopsy six and a half years later, carcinoma of the stomach was found. The fifth patient was first seen in 1942 and could not have surgical treatment because of concomitant disease. He had apparent healing of his gastric ulcer during medical management, but at his death in 1945 a clinical diagnosis was made of malignant gastric lesion; autopsy was not performed. The sixth patient, first seen in 1943 and managed with ambulatory treatment with complete healing, was reported by his referring physician to have died four years later from a gastric lesion that was suspected of being malignant. No autopsy was performed. The seventh patient, first seen in 1945, refused operation and died in 1952.

TABLE 3.—*Clinical Evaluation of Results in 380 Patients with Resected Benign Ulcer*

	Good		Fair		Poor		
Follow-Up Period	No.	%	No.	%	No.	%	Total
2 mo.-2 yr	110	83.3	16	12.1	6	4.5	132
2- 5 yr	102	74.5	23	16.8	12	8.7	137
5-10 yr	55	70.5	15	19.2	8	10.2	78
10-25 yr	32	96.9	0	....	1	3.0	33
Total or per cent	299	78.7	54	14.2	27	7.1	380

TABLE 4.—*Clinical Evaluation of Results in 397 Patients with Medically Treated Benign Ulcer*

	Good		Fair		Poor		
Follow-Up Period	No.	%	No.	%	No.	%	Total
2 mo.-2 yr	107	81.9	6	4.7	13	10.3	126
2- 5 yr	49	64.5	15	19.7	12	15.8	76
5-10 yr	70	72.9	14	14.6	12	12.5	96
10-29 yr	72	72.7	20	20.2	7	7.1	99
Total or per cent	298	75.1	55	13.8	44	11.1	397

RECURRENCES AND MORTALITY

One hundred forty patients had recurrent gastric ulcer; 96 were operated on and 44 were not. In the group that underwent operation 81 had benign lesions and 15 had malignant lesions. Of the 81 patients whose benign lesions were proved pathologically, 10 had more than one recurrence. Three of the group with malignant lesion had more than one recurrence. Of the 44 patients who had recurrence and were not operated on, 41, because of x-ray and clinical evidence of healing, were considered to have had benign gastric ulcers; 7 of these patients had multiple recurrences. Three of the group without operation had malignant ulcers, and one of them had had more than one recurrence. Recurrence was usually considered a definite indication for surgery, and our findings confirmed the validity of this policy, since malignancy was found in 16% of the recurrent ulcers that were operated on, an incidence that is appreciably higher than the over-all incidence of malignant ulcers in the total series (8.8%).

Deaths in the Postoperative Period.—There were 497 patients who had a surgical and/or pathological diagnosis of benign gastric ulcer. Twenty-three (4.85%) of the 474 patients, who had gastric resection, died in the postoperative period. There were 6 postoperative deaths among the 23 patients who had surgical procedures related to their benign gastric lesions. Eleven of the total number of 29 deaths occurred before 1944; of these, 4 were from pulmonary embolism and 7 were in patients over 65 years of age. Eighty-one patients had a surgical and/or pathological diagnosis of malignant ulcer. Sixty of these had resection, and two died postoperatively. Twenty-one patients had other surgical procedures and six of these died postoperatively.

Deaths After the Postoperative Period.—Sixty-four patients who were operated on died. Of the 44 patients with benign gastric ulcer in the group, 3 died, cause unknown, after being followed for three, four, and five years, respectively. One patient died of carcinoma of the stomach (proved pathologically) five years after resection for benign ulcer (proved pathologically). Ten died from malignant growths other than gastric cancer. In this group, there were three with carcinoma of the pancreas and one with carcinoma of the rectum. Thirty patients died of known causes unrelated to the stomach: 10 died in less than five years, 3 were followed five years, and 17 were followed more than five years after resection. Of the 20 patients with malignant ulcer, 18 died of carcinoma of the stomach and 2 died of pulmonary embolism after other surgical procedures; one of these died after a resection for jejunal ulcer. Of this group 2 were followed for 6 years, one for 6½ years and one for 11 years before death.

Deaths in the Medically Treated Patients.—Seventy-one patients with gastric lesions originally diagnosed as benign died. In five the cause is unknown. Seven (1.7%) died of carcinoma of the stomach; four of these were treated less than five years and three more than five years. Three patients died from malignant lesion in the digestive tract: one from carcinoma of the liver, the second from carcinoma of the colon, and the third from carcinoma of the esophagus. No evidence of malignant gastric lesion was found in these patients. Eight patients died of carcinoma not related to the digestive tract. Forty-eight patients were known to have died of nonmalignant disease. Eighteen of these 71 patients were followed more than 11 years; 10 were followed from 5 to 10 years.

These statistics indicate that the mortality from cancer of the stomach occurring in the unoperated cases was 1.7% whereas the operative mortality in resected cases for benign ulcer was 4.85%. There were 29 patients (2.9%) in whom death, which was attributable to carcinoma of the stomach, possibly could have been avoided by immediate operation. Of this group, 7 patients had no surgery and 22 were operated on after two months of medical treatment.

If all five patients in the group that did not undergo surgery who died of causes unknown are assumed to have died of cancer of the stomach, although this is hardly probable, this addition brings the percentage up to 3.4, which is still lower than the over-all surgical mortality in benign ulcer (4.85%). It is recognized that surgical mortality has declined in recent years, and that gastric resection has become progressively safer in all age groups. It is, however, also shown in this study that the majority of errors in clinical judgment in medical management occurred chiefly in the same years when surgical risk was high and that medical treatment for differentiation of benign and malignant ulcers has made what might be considered parallel progress with surgery.

SUMMARY AND CONCLUSIONS

One thousand cases of gastric ulcer are presented, 912 benign and 88 malignant. Four hundred ninety-seven patients of the group with benign ulcer were operated on; suspected malignancy was the indication for operation in more than half of these patients. Seven of the group with malignant ulcer were not operated on; in four of these, operation could not be performed in any case. One hundred ninety-five patients with benign ulcer who did not undergo surgery were followed for more than 5 years and, of these, 99 for more than 10 years. Seventy-three per cent of this latter group were without gastric symptoms, and a comparison of the morbidity statistics shows little difference between the results in the groups undergoing operation and those who did not.

It seems reasonable, therefore, to conclude that a month or less of intensive medical management in many cases of gastric ulcer is justified. The responsibility for differentiation is great and requires the utmost vigilance, but it seems to us that the responsibility should be borne by the gastroenterologists in the interest of avoiding unnecessary surgery and of maintaining unimpaired digestive physiology.

605 Commonwealth Ave. (15) (Dr. Smith).

Bone Bank.—Preserving bone in a penicillin-streptomycin solution is simple, requires no special equipment or trained personnel, and is inexpensive. One hundred grafts have been done using bone so preserved. There have been no infections. All bone preserved by this method and used as a graft has integrated.—Lieut. Col. R. W. Augustine and others, Penicillin-Streptomycin Bone Bank, *U. S. Armed Forces Medical Journal*, November, 1953.

ROLE OF THE DERMATOLOGIST IN THERAPY OF CANCER OF THE SKIN

CHAIRMAN'S ADDRESS

John H. Lamb, M.D., Oklahoma City

My interest in carcinoma of the skin stems from a paper I read before the Section on Dermatology and Syphilology in 1938 on radiation treatment of cancer of the lip. Since that time much of my professional work has been devoted to improvement of radiation techniques and study of cancer of the skin in the literature and in seminars. When I began this career of active scientific study three years after entering dermatological practice, I inherited from my predecessors knowledge of the then standardized physical agents, radium and x-radiation.

I did not have to combat the doubters who stated that these agents had no scientific value, that they were dangerous implements that no one could control, and that sufficient dosage to cure a cancer would also destroy the normal tissues. Neither did I have to spend time educating the public that cautery, surgery, and zinc chloride pastes had been replaced by more effective and simpler agents that produced better cosmetic effects and cure in a high percentage of cases. I could devote my time to better treatment with variations of infiltration and kilovoltage of x-rays to such locations as the ear, alae of the nose, nasocheek folds, scalp, tongue, and buccal surfaces, where lesions had been heretofore incurable with this therapy. I could learn the tolerance doses of the normal tissues in these locations, and, finally, I also had time for pathological study of many varieties of skin neoplasms. My predecessors had so established their group as "dermatologists who were cancer specialists" that no limit was put on the tools used to cure the cancer.

The kilovoltage of x-rays available ranged from 60 to 200 kv., the half-value layer from 0.9 mm. Al to 0.5 mm. Cu, with a radium emanation reservoir of 200 mg. for external radiation and over 100 mg. in low-intensity radium element needles. This heritage was a great stimulus to a then young man who was entering an era in his specialty in which many factors seemed to be narrowing and limiting the dermatological field of practice even in cancer therapy. It is apparent, therefore, that one cannot discuss the role of the dermatologist as a cancer specialist without a historical consideration of those who established our role today and how they left us this great heritage.

HISTORICAL ROLE OF DERMATOLOGISTS AS CANCER SPECIALISTS

The dermatologists were the first to study experimentally the recovery of normal tissues from radiation. Kingery,[1] a dermatologist, was the first to publish the theory that irradiation produced some hypothetical decomposition product in the tissues. Recovery from radiation effect would be in direct ratio to elimination of this product, which, he assumed, would be subject to the same law as certain other chemical and biological reactions and follow a logarithmic curve. He pioneered in a field that brought to the forefront the importance of the three factors in computation of dosages, namely, the quantity of radiation, the space or amount of tissue treated, and the factor of time. These principles have given us protraction of radiation technique and knowledge of tissue recovery, all based on these excellent early experiments of Kingery, followed by other physicists and radiotherapists such as Duffy, Arneson, and Voke,[2] MacComb and Quimby,[3] and MacKee, Cipollaro, and Montgomery.[4]

At the second annual Pusey dinner, Dr. Leonard Weber [5] reviewed the early days of our greatest pioneer in roentgen therapy, Dr. William Allen Pusey.[6] In 1899, four years after Dr. William Conrad Roentgen discovered the new ray, Dr. Pusey went to Vienna to study the x-ray techniques of Drs. Leopold Freund [7] and Eduard Schiff, who were pupils of Roentgen's. Dr. Freund not only had given the x-rays therapeutic trial but had designed proper apparatus and offered a careful technique for its safe employment. Dr. Pusey returned to Chicago inspired with the possibilities of this new agent after his visit with Dr. Freund. On an old manila envelope he listed a generalization of the indications for the therapeutic use of x-rays, then enlarged upon these indications. With a few exceptions they still stand today.

Dr. Pusey started with a crude, gas-filled roentgen tube and mechanized rectifier and attempted to apply these principles to treatment of malignant lesions. He treated many malignant lesions of the skin, both superficial and deep, on the eyelids, the lower lip, etc., with great success. He also treated the hopeless and less favorable tumors and metastases for his surgeon friends. Palliative results in recurrent carcinoma of the breast were surprising.

Dr. Pusey was the first to advocate routine prophylactic irradiation postoperatively in cancer of the breast. He reported his results with filtered x-ray therapy on leukemia with roentgen irradiation of the spleen and its

Read in the Symposium on Cutaneous Malignancy, An Appropriate Segment of Dermatology, before the Section on Dermatology and Syphilology at the 102nd Annual Meeting of the American Medical Association, New York, June 3, 1953.

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2. Duffy, J. J.; Arneson, A. N., and Voke, E. L.: The Rate of Recuperation of Human Skin Following Irradiation: Preliminary Report, Radiology **23**: 486 (Oct.) 1934.

3. MacComb, W. S., and Quimby, E. H.: The Rate of Recovery of Human Skin from the Effects of Hard or Soft Roentgen Rays or Gamma Rays, Radiology **27**: 196 (Aug.) 1936.

4. MacKee, G. M.; Cipollaro, A. C., and Montgomery, H.: X-Rays and Radium in the Treatment of Diseases of the Skin, ed. 4, Philadelphia, Lea & Febiger, 1946.

5. Weber, L.: William Allen Pusey—Pioneer in Roentgen Therapy, read at second annual Pusey Dinner, Oct. 15, 1947.

6. (*a*) Pusey, W. A.: The Treatment of Epitheliomas of the Skin with Report of Cases, Clin. Review **13**: 247 (Jan.) 1901; (*b*) Roentgen Rays in the Treatment of Diseases of the Skin: A Review of Recent Literature and a Personal Experience, J. A. M. A. **37**: 820 (Sept. 28) 1901. (*c*) Cases of Sarcoma and of Hodgkin's Disease Treated by Exposures to X-Rays: A Preliminary Report, ibid. **38**: 166 (Jan. 18) 1902. (*d*) Radium and Its Therapeutic Possibilities, ibid. **43**: 173 (July 16) 1904. (*e*) The Practical Application of Roentgen Rays in Therapeutics and Diagnosis, Philadelphia, W. B. Saunders Company, 1903.

7. Freund, L.: Verhandl. d. XII Internat. Aerzte-Kongresses. "Sektion f. Haut- und Geschlechtskr." (Sitzung 13-25, August 1896). Wien. med. Wchnschr., 1897, No. 10 and 19. Wien. med. Presse, XLVI, 1898, Wien. med. Presse, XXXI, 1899.

immediate effect on diminishing the number of white cells in the circulatory blood. He became interested in the therapeutic use of this new agent for skin diseases and presented a case of pseudoleukemia or Hodgkin's disease at the Chicago Medical Society on Feb. 26, 1902. Erythema was produced, and the affected glands diminished rapidly in size. As early as 1902 he published many valuable papers on the use of x-rays in the cure of cancer, and continued to produce equally important papers throughout his active life. Dr. Pusey also edited a treatise on "The Practical Application of Roentgen Rays in Therapeutics and Diagnosis,"[6c] which had many editions. Dermatologists owe a great debt to this great teacher for his early vision in the use of this agent in our specialty.

One of Dr. Pusey's early pupils was a young Oklahoma country practitioner, Dr. Everett S. Lain, who in 1908 gave up a successful general practice,[8] and went to study with Dr. Pusey. Dr. Lain returned to Oklahoma and carried out the teachings of Pusey. He gave many hours of his time to the establishment of cancer clinics over the state of Oklahoma. He became the Oklahoma representative of the American Cancer Society in this area. Thus, all of the experience of Pusey and Lain was accumulated, digested, and improved upon, then passed on to us. Our present day methods rest upon these foundations. Similar dissemination of this knowledge in the therapeutics of cancer has taken place all over this country. In some areas the seeds have fallen on fallow ground, in others on fertile soil.

DERMATOLOGICAL TRAINING FOR CANCER SPECIALIST

Since the commonest form of cancer in the male, and the third most frequent in the female, is cancer of the skin, the majority of the cases are first seen by the dermatologist. The training of a dermatologist teaches him first to be accurate in direct inspection of all skin changes. He is trained to know all forms of precanceroses and their transition to malignant lesions. Ninety-five per cent of all malignant skin diseases can be diagnosed by clinical evaluation by most dermatologists.

Dermatologists are trained to differentiate nevi clinically and microscopically, an exceedingly difficult differential to many others. They are also trained to diagnose other skin conditions which in the early stages resemble precancerous keratoses. Lupus erythematosus offers such a problem on the face. Several cases have been seen in which heavy radiation was applied to small, single lesions of lupus erythematosus, which later spread in annular, discoid plaques typical of this disease.

The dermatologist is the logical cancer specialist because of his training as a therapist. In treating the benign lesions of the skin, he learns a great deal about the tolerance of the skin for radiation. Various degrees of radiation reactions are easily discernible, and he has a "feel" of depth perception to determine the extent of the lesion and many other minor but important factors in dealing with malignant disease of the skin.

SOME ESSENTIALS FOR THE CANCER SPECIALIST

The dermatologist cannot expect a superior reputation among both patients and physicians unless he follows some definite principles to become a cancer specialist. First, his approach, therapy, and results must satisfy the patients. In our practice, x-ray and radium therapy is the method of choice, since patients are pleased with the more effective modern radium and x-ray therapeutic methods for the following reasons: 1. They are simple. 2. There are no fears of "cutting on a cancer." Patients have a definite fear resulting from a lay idea that "cutting" spreads the lesion. 3. Cosmetic results are excellent. Later atrophic sequelae are avoidable with filtration of x-ray therapy and with the gamma rays of radium. The skin erythema dose is much higher for gamma rays of radium (1,000 r) and heavier filtered x-rays (400 to 500 r). Thus a much higher total dosage can be given with a lower number of skin erythemas.

Another factor of importance is cooperation and honesty with general practitioners. Interest in palliation therapy and in all hopeless cancer conditions must be maintained.

Also essential is cooperation with surgical staffs who are themselves cooperative and appreciate the true value of radiation techniques. Domination of cancer clinics over the country by noncooperative surgeons who are opposed to radiation treatment militates against effective utilization of these physical methods and their benefits to the patient, with regard to both curative and palliative effects. The progress made in the field of cancer surgery, however, is truly as remarkable as that made in radiotherapy.

X-ray equipment should be adequate. There is no finer investment than x-ray equipment that will withstand heavy usage. All ranges of kilovoltage should be included, from a low of 60 kv. to at least 140 kv.

It is also important to buy or rent adequate radium, i. e., three 5 mg. half-strength plaques, three 10 mg. half-strength plaques, four 5 mg. radium needles in platinum, ten 1.5 mg. (2 cm. length) interstitial radium elements, low-intensity needles, six 2 mg. interstitial radium elements, low-intensity needles, and eight long 2 mg. interstitial radium element needles 44 mm. in length. The dermatologist should be equipped to aid in treatment of patients for whom his treatment has failed, i. e., those with metastatic lesions, with heavier filtration and higher kilovoltage or low-intensity, interstitial radium element needles.

Whenever cancer is suspected, it is imperative that physical examinations by the dermatologist be complete, with special attention to the vaginal orifice, oral cavity, breasts, and genitalia. The method of treatment must be rational and adequate and chosen most carefully. A frequently justifiable criticism of many radiotherapists who treat cancer is that the majority "underdose" with radiation, then follow-up with electrodesiccation or electrosurgery to produce the cure. In 1935 this was certainly true in our office; two patients daily were treated with another round of filtered x-ray therapy, cautery, or electrosurgery. Today, with proper dosage, we are approaching a 100% cure rate with the first treatment.

No one method is entirely adequate—all methods must be available and understood by the dermatologist. Each malignant lesion must be studied carefully as to (1) location of lesions, as normal tissues in various locations react differently to radiation; (2) depth; and (3) extent. With the excellent progress of cancer education

8. Lain, S.: Pioneering in the Use of X-Rays and Radium in Oklahoma, privately published monograph, 1952.

throughout this country, the large, infected epitheliomas of the old days are gone; however, one or two such lesions are still seen weekly. These are the real test for the various methods of therapy, since most methods will handle the small, early epitheliomas.

Microscopic study of the tumors must be a part of the dermatologist's work as a cancer specialist. It is recommended that more dermatologists become adept in the study of histopathology of the skin in order that they may study their own cancer tissues. It is encouraging to see the interest on the part of dermatologists in pathology over the past 10 years. However, I do not believe in the great importance that is being placed on the positive biopsy report; the examination, palpation, and history are of equal importance. The clinical diagnosis is based on such factors as (*a*) the history of growth of the lesion from a precancerosis; (*b*) a pearly consistency; (*c*) the presence of telangiectatic vessels over the surface; and (*d*) the presence of other precanceroses.

The sin of treating clinically malignant lesions that have been reported as microscopically benign with heavy radiation is far less than that of underestimating the same growth because of several pathological reports of nonmalignancy. This is particularly applicable when the lip and buccal cavity areas are involved. The pathological report of many biopsy specimens removed from clinically positive lesions in the buccal mucosa will be leukoplakia or leukokeratosis, nonmalignant. Nevertheless, by observation and experience it can be seen that they are already malignant and should be treated as cancer.

The biopsy has been established by many therapists as a guide for determining the dosage for each type of cancer. Our dosage is approximately the same for all types of skin cancer—be it basal or squamous. We have a very high regard for any type of skin cancer. Microscopic analysis from one tiny segment of a lesion has never given us a feeling of safety in the basal types. In the past 20 years we have had more trouble with under-radiated and, finally, radioresistant, infiltrative types of basal cell lesions than with squamous cell cancers, which everyone is taught to respect.

The biopsy presents another pitfall in the hands of the general surgeon or general practitioner who takes a small biopsy specimen in a clinically positive case and, on receiving a negative pathological report, delays radical treatment for several months while the typical cancer develops. If the lesions are borderline clinically, a biopsy specimen should be removed and therapy postponed until the tissue is studied.

For the young cancer specialist, the biopsy should be a routine procedure on each cancer patient to protect him, but as the clinical judgment becomes more accurate it need not be made routine but left to the judgment of the therapist. Many of our patients have over 10 cancers. The expense of the biopsies in such instances would preclude any further treatment of the cancers. In certain locations the removal of a biopsy may spoil the cosmetic results and, by subsequent infection, interfere with the radiation effects in such locations as the upper and lower eyelids. I plead that, if a biopsy is performed, minute slices or a scissor-bite portion of the active growth is all that is necessary.

Surgery is reserved in our practice for infiltrating basal cell carcinomas that have been improperly irradiated and are radioresistant; it is also used where the skin about the tumor will not heal when the cancer is destroyed by desiccation and curettage. Surgery is the preferred treatment for melanomas and cancers larger than 1.5 to 2 cm. on the dorsal surface of the hands and fingers. Many cancer therapists (Martin [9]) advocate electrosurgical removal of large, fungating portions of the growths before radiation is instituted. However, with proper use of varying kilovoltage and filtration, these large masses melt away and no electrosurgery is at all necessary, as it is only more painful and shock-producing to the patient, upsets the cancer bed, and disrupts the exact totaling of dosage. Any trauma may increase radiation effects. To destroy these large, fungating surface masses, unfiltered x-rays of from 1,500 to 2,000 r units in two divided doses, 100 kv., a half-value layer of 0.9 mm. Al are added to the usual heavier filtered x-ray and gamma radiation therapy. The cancer mass is closely windowed, protecting the normal skin. This radiation acts almost as an escharotic to the fungating mass of vessels, pyogenic infection and cancer cells, and completely melts the lesion away. The penetration of this x-ray dose in the tumor bed is so small as to be almost negligible in figuring the total dosage.

Electrosurgery and electrodesiccation with curettage have their place in selected cases and are the favored methods of many dermatologists. Because of the high rate of cures and the success of x-ray and radium therapy in our group, electrodesiccation is reserved for precancerous lesions and electrosurgery for radiation failures.

If radiation is to be used, the total dosage must be estimated, a treatment schedule planned for each individual case, and then therapy effectively carried out. One must know the principles of radiation. For 30 years we have used a combination of x-rays and gamma radiation from a radium source, either external or interstitial. This combined use of x-rays of two different qualities, or combined with radium, has been employed by Quick,[10] Smithers,[11] Quimby and Pack,[12] and many gynecologists who combine large dosages of intravaginal gamma radium with 2,000 to 3,000 r units of filtered x-rays. Quimby and Pack [12] as early as 1930 proved experimentally that with a combined use of gamma rays of radium and x-rays one-third more radiation energy was required to produce a skin erythema than was required with x-rays or radium alone. It has been concluded by these investigators that much greater quantities of radiation can be delivered to a carcinoma, with safety to normal tissues, by a combination of two different qualities of radiation than the same total dosage from a single quality.

On this principle has evolved our method of therapy.[13] Briefly, it is 3,000 to 5,000 r of x-rays in divided dosage

9. Martin, C. L., in Pohle, E. A.: Clinical Radiation Therapy, Philadelphia, Lea & Febiger, 1950, p. 867.
10. Quick, D., in Clinical Therapeutic Radiology, Portman, U. V., editor, New York, Thos. Nelson & Sons, 1950, p. 128.
11. Smithers, D. W.: The X-Ray Treatment of Accessible Cancer, London, William Wood & Company, 1950.
12. Quimby, E. H., and Pack, G. T.: Further Studies on the Skin Erythema with Combinations of Two Types of Radiation, Radiology **15**: 30 (July) 1930.
13. Lamb, J. H.: Cancer and Precancers of the Skin, in Current Therapy 1951: Latest Approved Methods of Treatment for the Practicing Physician, Conn, H. F., and others, editors, Philadelphia, W. B. Saunders Co., 1951, p. 430.

to tumors, with the addition of external radium of a dosage of 3,000 to 4,000 gamma r units. This produces excellent results, and the tissue effect does not resemble that of radiation given by a single quality used alone, such as x-rays in divided doses for a total dose of 7,000 r units. This could be predicated upon the fact that there is a much lower number of erythema doses from this combined treatment than if the same dose is given with x-rays alone.

When interstitial radiation is used (and also gamma radiation), 2,000 r units of x-rays, 100 kv., 9 in. distance, half-value layer of 0.9 mm. Al, in one single dose, or, if the area is large, in two divided doses one week apart, are added, giving 6,500 gamma r plus 2,000 r x-rays. For the fungating, largest tumors, the x-rays may be of two different qualities as described previously, both half-value layer 0.9 mm. Al, at 100 kv. and 4.5 mm. Al, at 120 to 140 kv. By combining these various qualities of radiation, our cures are increased to about 98% and 99%.

In treating 700 to 800 skin cancers yearly, the recurrence rate is from 1% to 2%. In 1952, only six cases of ulcerated, infectious lesions resulting from traumatic injury in the old radiation site were seen from radiation therapy given two to five years previously. These are cured in most cases with three to six injections of 100,000 to 200,000 units of penicillin in saline solution under and around the lesion, after procaine anesthesia. After these heavy doses as outlined are administered, care must be exercised in treating the recurrences with desiccation and curettage, since healing will not be rapid. Electrosurgery is the preferred method, and the entire old radiation area should be removed.

Podophyllin, 20% in tincture of benzoin, has a very important place in treatment of the recurrent cancers in our own cases as well as in those of other radiotherapists. Some of these cures have been as dramatic as those reported by Smith and Garrett.[14] Podophyllin seems to be a better agent in old, radioresistant tumors than in fresh, untreated lesions. It is especially satisfactory in radiation cancer in physicians or dentists or in actinic cancer occurring in areas previously over-treated by x-rays for such conditions as acne or eczema. Two dentists and one orthopedic surgeon have been saved from amputation and plastic surgery by this method. The permanence of cure must await time.

Moh's treatment is of value in these cases also, but in the South and Midwest many notorious charlatans and cancer patients themselves have developed and used this method, except that there is no microscopic control on tissue removal as in Moh's method. Therefore it is in disrepute among the profession and the public alike.

SUMMARY AND CONCLUSIONS

Experiences in treating cancer over a period of 18 years, sometimes unsuccessfully, have been briefly reviewed. No patients with any one disease produce more satisfaction and pleasure to the cancer physician than the patients with skin cancer. They need treatment and are pleased with results. Three or four such cases daily help to eliminate the discouragement experienced in treating chronic dermatoses. I conclude by pleading that more centers that have developed a large cancer clientele give thought to short courses each year in radium, x-ray, and other techniques for postgraduate students. Such courses would substitute for the apparent lack of training in some of our dermatological educational institutions and give encouragement to—not belittle—those dermatologists today who are broadening the scope of dermatology, be it in allergy, radiation therapy, or plastic or electrosurgery.

Medical Arts Bldg. (2).

14. Smith, L. M., and Garrett, H. D.: Resin of Podophyllum in Treatment of Cancerous and Precancerous Conditions of Skin: Effect on Basal Cell Epithelioma and Seborrheic, Senile and Radiation Keratoses, Arch. Dermat. & Syph. **61**:946 (June) 1950.

COMPARATIVE PHYSIOLOGY OF THE KIDNEY

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We cannot properly speak of physiology, and therefore we cannot speak of comparative physiology, until the time of Harvey. But it is worthy of emphasis that the discoverer of the circulation utilized the comparative method as extensively as any man since his time. It is something of a paradox that Harvey, in observations on the circulation of the blood, failed to challenge the Galenic view on how the blood got from the arteries to the veins but was content to believe that it seeped through the soft organs simply as water seeps through sand.

CONTRIBUTIONS OF MALPIGHI

The microscope, as improved by Galileo, was available in Harvey's time, but either because of lack of acquaintance with the instrument or lack of interest in the finer structure of the body, he failed to use it. It was Galileo's compatriot, Marcello Malpighi, who introduced this instrument into the study of the structure and function of the animal body. Apparently from youth Malpighi had been amusing himself with a microscope of sorts. Shortly after completing his medical training, he began to utilize it so profitably that four sciences now claim Malpighi as their own. With Nehemiah Grew, he pioneered in the study of plants, and his "Anatomy of Plants," published by the Royal Society, entitles him to be considered with Grew as one of the founders of vegetable morphology. Aristotle, Fabricius, and Harvey had all studied the chick embryo, but Malpighi was the first to give an adequate description of how a little white, opaque spot in the hen's egg is transformed into the feathered, living bird, and he is justly called the founder of embryology. At the request of the Royal Society, he undertook an exhaustive study of the silk worm, describ-

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ing its life habits, its metamorphosis, its gross structure, and the fine anatomy of its viscera, and giving his name to the Malpighian tubules that constitute the excretory organs of the insects. This treatise, with many other contributions, entitles him to be called the first profound student, after Aristotle, of comparative antomy. It is, however, through his studies of the fine structure of the soft tissues of the body that medical science lays claim to him as the founder of microscopic anatomy.

It was in Malpighi's study of the structure of the lungs, published in 1661, or four years after Harvey's death, that he discovered the capillary circulation, thus completing the gap between the arteries and the veins. Five years later, in a volume entitled "The Structure of the Viscera" (1666), Malpighi described with extraordinary acuity the major microscopic features of the brain, liver, lymph nodes, spleen and kidney. The year before he began his studies of the kidney, Lorenzo Bellini, a 19-year-old Italian youth, had demonstrated by dissections of the deer that what had theretofore been considered to be fibrous strands radiating throughout the kidney were in fact hollow tubes or ducts that radiated inwards from the pelvis to form an elaborately arborized system of caniculi. It was perhaps in tracing Bellini's ducts backwards into their finest ramifications that Malpighi, with a microscope magnifying some 30 times, found that the smallest order of tubes began as spherical bodies or corpuscles, each of which was composed of an elaborate tuft of the capillaries that he had discovered in the lungs. Malpighi satisfied himself that the capillaries were connected with the smallest arteries, and he surmised, if he did not prove, that they were also connected with the efferent veins. He also surmised, but did not establish, that the corpuscles were individually connected with the uriniferous tubes, and that they played an important part in urine formation.

153
53

NINETEENTH CENTURY CONTRIBUTIONS

Here, in effect, the matter of renal anatomy rested until 1842, when William Bowman, then a young demonstrator of anatomy at Kings College, London, gave the definitive description of the vertebrate nephron in what is a truly classic paper. It was Bowman's signal achievement to demonstrate that the space around Malpighi's capillary tuft communicates freely with the uriniferous tube so that any fluid separated from the capillaries drains into the latter, but he also described the general structure of the Malpighian corpuscle and of the uriniferous tube in such accurate terms that they could today well serve as an introduction to any text book on renal anatomy. Bowman used a microscope having a magnifying power of approximately 300, but he worked entirely by teasing the kidney apart and without the aid of aniline dyes that had not yet been invented.

Considering that Bowman published only one paper on the kidney, his work was as comprehensive in the matter of comparative anatomy as that of Harvey and Malpighi. Before arriving at his generalizations on renal anatomy, he satisfied himself of the correctness of his descriptions by studying the kidney in man, the badger, dog, lion, cat, mouse, squirrel, guinea pig, horse, parrot, tortoise, boa constrictor, frog, and common eel. Had he happened to examine an aglomerular fish (of which there were several species in the coastal waters of England), his paper, which set the pattern of renal physiology for nearly 100 years, would certainly have had an entirely different cast.

In speculating about the mechanism of urine formation, Bowman logically assigned a different role to the Malpighian corpuscle and to the epithelial tubule. He saw the corpuscle as uniquely designed to separate water from the blood across the capillary tuft, but he believed that all the solid constituents of the urine were added to this water as a secretion from the tubular epithelium. His notion of secretion was that of his day, namely, that the secretory epithelium is cast off entirely in the formation of the secretion by a process of disruption or dissolution of the cell. In this view he conceived that the water from Malpighian corpuscle was necessary to wash the disgorged contents of the epithelial cells down the tubule. In this matter he was not dogmatic, however; recognizing that he was endeavoring to demonstrate a doubtful hypothesis by an explanation more doubtful still, he adds that "Parallel lines of inquiry into the anatomical varieties of the Malpighian corpuscles and the uriniferous tubes, and into the chemistry of their secretion in the different kinds of animals and in various stages of their development, could scarcely fail to confirm or to confute what has [here] been advanced."

Bowman failed, in point of fact, to grasp the simple, physiological implications presented by the fine anatomy of the Malpighian corpuscle, a failure that was corrected two years later by Carl Ludwig, professor of anatomy at Marburg, who saw in this corpuscle a beautifully contrived, mechanical device permitting the separation from the blood, by simple process of filtration, of a large quantity of cell-free and protein-free fluid, sufficient in amount to contain all the urinary constituents. Accepting this basic premise of the filtration of a large quantity of fluid, the formation of a concentrated urine must be effected by the reabsorption of a considerable fraction of the filtered water during the passage of the fluid down the tubule. In Ludwig's view, Bowman's secretion by desquamation of the uriniferous epithelium became superfluous and questionably pertinent to urine formation, and Ludwig dismissed it as an improbable hypothesis.

Ludwig's filtration-reabsorption theory met with opposition chiefly from Rudolf Heidenhain, of Breslau, who had discarded the older theory of secretion by cellular desquamation in favor of a continuing intracellular process by which substances, either foreign or native to the blood, were transported from the blood to the urine without breakdown of the epithelium. Thus Heidenhain was perhaps the first to advance the modern view of tubular secretion.

MODERN THEORY OF URINE SECRETION

The differences in Ludwig's and Heidenhain's views assumed the form of seemingly irreconcilable theories and engendered a conflict that persisted throughout the last half of the 19th and into the first half of the present century. The Ludwig filtration-reabsorption hypothesis obtained strong support from Arthur Cushny, then at University College, London, in his 1916 Sidney Ringer lecture, subsequently published in monographic form under the title "The Secretion of Urine." After a careful review of the literature, Cushny failed to see wherein the

"secretionists" had established their point, and he marshaled the evidence for the Ludwig hypothesis under the general term of the "Modern Theory of Urine Secretion" because, as he says, his theory rested not on the work of any one man but on the work of many.

Though A. N. Richards had long been interested in the kidneys, as studied in perfusion experiments, it was one of Krogh's papers on the capillary circulation, which had just been published, that launched Richards into his epoch-making micropuncture studies in the frog and Necturus. Between the years 1921 and 1935 Richards and Walker and their co-workers, in a series of brilliant studies that are widely known, translated the Ludwig filtration-reabsorption hypothesis from the realm of theory into fact and laid the foundations for our knowledge of the detailed reabsorptive operations of the proximal and distal segments of the renal tubule.

The question of tubular excretion remained, however, a matter of controversy. That the tubules could excrete some substances, and notably phenolsulfonphthalein, was supported in this country by E. K. Marshall at the medical school of the Johns Hopkins University. In retrospect, I believe that the renal excretion of phenolsulfonphthalein in the dog, as argued by Marshall and Vickers in 1923, is the first definitive demonstration of tubular excretion in any animal, but it was only after Marshall and Grafflin and, independently, Edwards and Condorelli, began their studies on the aglomerular marine fishes that the reality of tubular excretion received general recognition.

Up to the fourth decade of this century, problems in renal physiology had been of a qualitative nature and largely involved qualitative answers. After 1932, however, as reliable methods became available for measuring the central operation of glomerular filtration in experimental animals and in man, renal physiology was rapidly transformed into a quantitative subject. Tubular excretion has now been demonstrated to play almost as important a part in urine formation as tubular reabsorption. Both operations, together with glomerular filtration, have become subjects of such wide investigation that we can fairly say that we possess a larger body of precise, quantitative knowledge on the kidney than on any other organ.

RELATION TO EVOLUTION

To summarize the many studies now available on the comparative physiology of the kidney, from the fishes up to man, would be impossible in any short period, and I must be content to emphasize that these studies have paid a great and unexpected dividend in the way of broadening our horizons with respect to the evolution of all the vertebrates, including man. May I recall to your memory the name of Claude Bernard, perhaps the greatest physiologist of the 19th century, and Bernard's epitome that the environment in which we live is neither air nor water, but the blood and body fluids that bathe all the tissues. This internal environment, as Bernard pointed out, is characterized by an extraordinary constancy of composition, and it is by virtue of this fact that the animal achieves a free and independent life. This idea of Claude Bernard's has been rated, in respect to physiology, in importance with Darwin's demonstration of evolution for biology. In truth, the two ideas are closely related, because the story of the evolution of the vertebrates is, in essence, the story of the evolution of the internal environment. I need scarcely emphasize to you that it is the kidney that is charged with the synthesis or regulation of this environment, an operation that it carries out in reverse, so to speak, by the circuitous processes of glomerular filtration and tubular reabsorption. Our entire internal environment is, in fact, thrown out of the body by way of the glomerular filtrate some 16 times a day, only to be captured by the renal tubules before it falls to earth, and it is in this process of recapture that the renal tubules perfect and maintain its composition. The progressive evolutionary elaboration of the kidneys to the point where we may live in a fluid the composition of which scarcely suffers any change is a story that can now, in some measure at least, be reconstructed from the data of comparative physiology.

Without this internal environment—that is to say, without the kidney—the first armored fishes could not have invaded fresh water 500 million years ago. It was the physiological crisis engendered by this invasion of fresh water that led to the evolution of the glomerulus as a device enabling the heart to pump water out of the body. Without subsequent improvements in the kidney there could have been no evolution of the air-breathing fishes of the Devonian period, which in subsequent periods supplied the first semiterrestrial amphibious animals, and through the Amphibia, the great dynasties of the Mesozoic reptiles. From these Mesozoic reptiles there came the warm-blooded mammals and such further improvements in the kidney as enabled the mammals to compete with, and finally to supersede, the reptilian forms. Warm-bloodedness fostered the evolution of the brain until, in the primates, the sense of sight came to dominate the sense of smell, culminating in the evolution of the human cerebral cortex, the most elaborate organ in all of animate creation for the mediation of consciousness with its manifold operations of perception, integration, volition, and imagination. When I reaffirm Bernard's thesis that we owe our physiological freedom to the constancy of our internal environment, I am but affirming that both the historic and immediate foundation of this freedom rests in the organ that both historically and immediately supplies us with this stable body fluid.

Harvey, Malpighi, Bowman, Ludwig, and Heidenhain could scarcely have forseen what consequences were to issue from their studies on deer, birds, snakes, frogs, and all manner of animals: but in the revolution that engulfed all biological science after the publication of Darwin's "On the Origin of Species by Means of Natural Selection," these fragments began to fall into a mosaic in which it is seen that, as the physicist John Tyndall said only 15 years after the publication of Darwin's book, "The doctrine of evolution derives man, in his totality, from the interaction of organism and environment through countless ages past. The Human Understanding . . . is itself a result of the play between organism and environment through cosmic ranges of time." Tyndall had, for a physicist, a remarkably comprehensive knowledge of biological science, but in 1874 not much was known about renal function. Otherwise, I believe that he would have mentioned the internal environment, and the kidney, in his philosophic epitome.

TREATMENT OF CHRONIC DISCOID LUPUS ERYTHEMATOSUS WITH QUINACRINE

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The article by Page [1] on the treatment of 18 patients with lupus erythematosus with quinacrine hydrochloride (Atabrine) has initiated widespread interest in the United States regarding this subject. As early as 1940, Prokoptchouk [2] reported the use of quinacrine (Acrichin) in 35 patients with lupus erythematosus and was impressed with its effectiveness. Popoff and Kutinscheff [3] observed remission of lupus erythematosus in six patients treated with quinacrine in 1941. Krynski [4] treated six patients during the period 1940-1945. Pseudoicterus developed in one patient, and another showed a temporary psychic disturbance. He concluded that the method was effective but that the high incidence of side-reactions probably made its more general usage unwarranted. It has since been shown that the American product Atabrine (quinacrine hydrochloride, U. S. P.) probably is less toxic and produces fewer side-effects than Acrichin the Russian product or its German analogue Atabrin.[5] Bispham,[6] in a series of 46,681 patients who received quinacrine for prophylaxis and treatment of malaria, observed only 38 instances of toxic reactions. Agress,[7] in a group of 3,000 patients, reported an incidence of untoward reactions in only one-twentieth of 1%.

In a survey of the toxic manifestations attributable to quinacrine, it is significant that these are almost without exception limited to the skin, hematopoietic system, central nervous system, the liver, and the eye. The cutaneous manifestations described include: (1) lichen planus-like, lichenoid, and eczematoid dermatosis,[8] (2) a toxic exanthem resembling typhus,[9] (3) exfoliative dermatitis,[10] pseudo-icterus,[11] (4) pigmentation resembling that of ochronosis,[12] (5) hemorrhagic capillary toxicosis,[13] and (6) hyperkeratosis of palms and soles.[14] Blood complications include: (1) hemoglobinuria,[15] (2) agranulocytosis,[16] and (3) aplastic anemia.[17] Temporary psychosis and psychoneurotic reactions have been rather frequently reported,[18] and occasionally a case of polyneuritis [19] has been presented. Eye changes include corneal edema,[20] keratitis,[21] and blindness.[22] Hepatic lesions include focal necrosis [23] and toxic hepatitis.[24]

Encouraging preliminary reports on the use of quinacrine in lupus erythematosus have begun to appear in the American literature. Cramer and Lewis [25] reported rapid improvement in six patients. Sawicky and his associates [26] observed prompt and definite improvement in 21 patients, complete clearing in 6, and failure to respond or relapse in 3. Wells [27] in a study of 12 patients reported a good response in 9 and complete clearing in 3, with 3 others considered as therapeutic failures. In one of these, itching and scaling of the palms occurred and in another, dissemination of the cutaneous lesions.

RESULTS OF STUDY

The present study includes 32 patients with chronic discoid lupus erythematosus who had been treated with quinacrine from February, 1952 (table). All but six of these patients had received previous therapy, other than quinacrine, for their condition. The dosage schedule used was 0.1 gm. of quinacrine hydrochloride twice daily for a period of two weeks and 0.1 gm. daily thereafter. Two patients continued on this regimen for one year. Two patients received the drug for only one month. All

Quinacrine Therapy in Thirty-Two Patients with Chronic Discoid Lupus Erythematosus

Case No.	Age	Sex	Duration, Yr.	Prior Treatment	Degree of Illness	Quinacrine Therapy, Mo.	Degree of Result, %
1	41	M	11	Yes	Severe	11	50
2	37	F	2	Yes	Severe	3	0
3	28	F	6	Yes	Severe	4	50
4	57	F	2	Yes	Mild	3	100
5	62	M	8	Yes	Moderate	5	50
6	37	F	8	Yes	Mild	3½	50
7	35	M	14	Yes	Moderate	4	50
8	41	F	15	Yes	Severe	4	50
9	21	F	8 mo.	No	Mild	6	50
10	32	F	6 mo.	No	Mild	2	0
11	43	M	20	Yes	Severe	12	50
12	40	F	6	Yes	Mild	3	50
13	35	M	14	Yes	Moderate	8	50
14	45	F	1	No	Mild	3	100
15	22	F	4 mo.	No	Mild	1	100
16	41	M	13	Yes	Mild	4	0
17	56	M	15	Yes	Moderate	3	100
18	54	F	10	Yes	Moderate	4	50
19	54	F	6	Yes	Moderate	3	100
20	35	F	14	Yes	Mild	2	100
21	56	F	6 mo.	No	Severe	5	100
22	29	F	8	Yes	Mild	3	50
23	53	F	13	Yes	Mild	1	50
24	28	M	1	Yes	Severe	6	100
25	55	M	21	Yes	Mild	2	100
26	47	F	3	Yes	Moderate	2	0
27	39	F	5 mo.	No	Severe	2	50
28	35	M	6½	Yes	Mild	3	0
29	45	M	11	Yes	Severe	2	50
30	37	F	5½	Yes	Mild	2	100
31	45	M	9	Yes	Mild	2	100
32	60	M	1½	Yes	Mild	2½	100

of the remaining patients were under continuous treatment for at least two months. Cases were classified as severe, moderately severe, and mild, depending on the extent of involvement. Results were evaluated on the basis of three categories: complete clearing, improved at least 50%, and failure. Twelve cases showed complete

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Because of lack of space, the bibliographic references have been omitted from THE JOURNAL and will appear in the authors' reprints.

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clearing. Fifteen showed at least 50% improvement, and five were considered failures.

Two patients showed a tendency to relapse while they were being treated with quinacrine. Neither showed a good initial response, and results of treatment in both were ultimately classified as failures. Two untoward reactions were observed. One of these was a severe generalized lichenoid and eczematoid dermatitis occurring after three months of therapy. The patient incidentally showed complete clearing of all lesions, and the drug eruption responded dramatically to cortisone therapy. The second reaction was very mild in character and was indistinguishable from pityriasis rosea. This occurred after four months of therapy.

From this study it would appear that the effects of quinacrine are rapid and dramatic in those cases of chronic discoid lupus erythematosus that will prove amenable to this therapy. In 10 of the 12 subjects in whom complete clearing resulted, the response was noted within three months. This is significant, for it is a generally accepted fact that the incidence of toxic reactions attributable to quinacrine increases with the prolongation of its administration beyond a period of three or four months. Furthermore, it is impossible to definitely state that improvement occurred in any instance in which therapy was continued beyond five or six months. The response to therapy apparently bears no relationship to age, sex, duration, severity, or previous treatment. Thus far, tendency to recurrence or relapse has not been observed in any of these patients in whom the disease has cleared completely or in patients who have initially shown marked improvement.

SUMMARY

A brief review of the preliminary reports on the treatment of chronic discoid lupus erythematosus with quinacrine (Atabrine) hydrochloride is presented together with a survey of the toxic effects produced by this drug. This study includes a group of 32 patients who had chronic discoid lupus erythematosus and who were treated with quinacrine, 0.1 gm. twice daily for two weeks and 0.1 gm. daily thereafter, for periods ranging from one month to one year. Twelve patients have shown complete clearing of all lesions. Fifteen patients have shown at least 50% improvement, while five have been considered failures. There have been two instances of toxic reaction. One was a severe, generalized, lichenoid and eczematoid dermatosis developing after three months of therapy. The other was a mild, transitory eruption, indistinguishable from pityriasis rosea, occurring after four months of therapy. Maximum response may be expected early in the course of quinacrine therapy, usually within three to four months. Thus, if therapy is not continued beyond this period, fewer toxic reactions may be expected. Thus far, relapse or recurrence has not been observed in those patients who showed complete clearing or dramatic initial response to therapy with quinacrine.

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V 1
195

INTESTINAL ANTISEPSIS IN SURGERY

Edgar J. Poth, M.D., Ph.D., Galveston, Texas

The modern concepts of intestinal antisepsis have developed during the past 12 years. Initially, certain sulfonamides, which were poorly absorbed from the gastrointestinal tract, were found to act locally to alter the bacterial flora. These compounds had relatively narrow antimicrobial spectrums, had little effect against the gram-positive organisms, and acted primarily as bacteriostatic agents against the gram-negative bacteria found in the gastrointestinal tract of man. While many of the sulfonamides have some activity, it was not until succinylsulfathiazole (Sulfasuxidine) was used by Knotts, Lee, Inui and myself [1] that the gram-negative flora of the bowel could be altered significantly and consistently. Many sulfonamides were investigated, but ultimately only three could be used as practical intestinal antiseptics. They were, in the order discovered, succinylsulfathiazole,[2] phthalylsulfathiazole (Sulfathalidine),[3] and phthalylsulfacetamide (Thalamyd).[4] Of these three, succinylsulfathiazole was the most promising and satisfactory, because it not only altered the gram-negative flora of the gastrointestinal tract but also aided in the mechanical preparation of the bowel.[5]

These substances had definite disadvantages. They had relatively narrow spectrums, and, being bacteriostatic, they could merely inhibit the multiplication of organisms. It was required, therefore, that the contents of the bowel be evacuated by mechanical cleansing of the irregular mucosal surface of the bowel to remove viable bacteria. This procedure requires a considerable length of time and is not effected consistently and satisfactorily in less than seven days.[6]

The antibiotics were subsequently studied as intestinal antiseptics. Streptomycin was the first,[7] and was immediately found unsatisfactory because of the rapid development of resistant organisms.[8] The gastrointestinal tract, with its complex structure, fecal content, and subjection to reinfection by oral ingestion of contaminated material provides an excellent site for the development of resistance.

When chlortetracycline (aureomycin) first became available in very limited quantities, it was used at the University of Texas Medical Branch in an attempt to treat poliomyelitis during the summer of 1948. I studied the stools of the patients treated and concluded that chlortetracycline was not an acceptable intestinal antiseptic.[9] The flora was altered on occasions, but not consistently,

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and it was soon demonstrated that Micrococcus pyogenes var. aureus (Staphylococcus aureus) would frequently grow out. Subsequently, this substance was investigated by Pulaski, Connell, and Seeley,[10] who also concluded that, in comparison to other available intestinal antiseptics, chlortetracycline possessed no advantages. Dearing and Heilman [11] published material in 1950 showing that chlortetracycline rapidly altered the bacterial flora quite satisfactorily, and it was proposed as an intestinal antiseptic.

Oxytetracycline (Terramycin) [12] was also proposed as a wide spectrum intestinal antiseptic with bactericidal properties. It possessed the same disadvantages as chlortetracycline. With continued use, it was noted that, even when chlortetracycline and oxytetracycline were not used as intestinal antiseptics, frequently nausea, vomiting, and bloody diarrhea developed.[13] Occasionally, a choleriformic type of disease would develop, with pseudomembranous colitis followed frequently and rapidly by death.[14] Only recently has it been demonstrated that this choleriformic disease is due to the overgrowth of Micrococcus pyogenes on approximately the third or fourth day when the other organisms are diminished and the naturally occurring antagonists of the staphylococci removed (fig. 1).[15] The population of staphylococci in the gastrointestinal tract of man is usually quite small.

I [16] first used neomycin as an intestinal antiseptic in December, 1949. It was immediately realized that this substance had strong bactericidal properties, rapidly eliminated bacteria from the gastrointestinal tract, and gave promise of being an excellent intestinal antiseptic. The response of the first 30 patients who were treated with neomycin alone was excellent. There was no indication that any organisms survived. It was early recognized that the yeasts grew out in large numbers immediately after elimination of the bacteria. Shortly after this series of patients was studied, three instances of Aerobacter aerogenes resistance were observed in rapid succession.[17] The incidence of early Aerobacter aerogenes overgrowth varied somewhat with the season of the year and was particularly likely to develop in this section of the United States during the summer months. Approximately 10% of the persons treated had persistent overgrowth of this organism. Obviously, this complication would reduce materially the value of neomycin as an intestinal antiseptic. Thereafter, phthalylsulfathiazole was given in conjunction with neomycin to inhibit the outgrowth of Aerobacter aerogenes. This combination closely approaches the requirements of an ideal intestinal antiseptic.

The ideal intestinal antiseptic should have the following properties [18]: (1) broad bacterial spectrum; (2) low toxicity for the host; (3) chemical stability in the presence of digestive ferments; (4) capacity to prevent development or overgrowth of resistant bacterial variants; (5) rapidity of action; (6) limited absorption from the gastrointestinal tract; (7) activity in the presence of foods or other foreign substances, thereby allowing adequate intake of foods and fluids; (8) capacity to aid in the mechanical cleansing of the bowel without causing dehydration; (9) inability to irritate the gastrointestinal mucosa; (10) noninterference with tissue growth and repair; (11) low dosage requirement; (12) solubility in water; (13) palatability; (14) inhibitive activity on excessive growth of fungi; and (15) restricted use, i. e., use only as an intestinal antiseptic. A satisfactory regimen of intestinal antisepsis must not permit the development of resistant pathogenic strains of bacteria or result in extensive absorption of the agent or agents from the gastrointestinal tract.

If a substance to be used as an intestinal antiseptic is absorbed even moderately from the gastrointestinal tract, the incidence of untoward secondary reactions will greatly limit its use in patients to be subjected to extensive operative procedures. Intestinal antiseptics, to be effective, must be given in such large quantities that, if absorbed, the untoward reaction rate will be prohibitively high.

A substance that is not absorbed from the gastrointestinal tract, is chemically stable, and is not destroyed in the bowel by digestion will remain active in the bowel until evacuated. This property is particularly desirable, because then the effect will continue during the period of

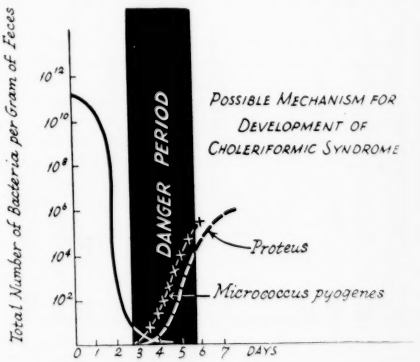

Fig. 1.—Representation of what may be the sequence of events when the so-called choleriformic syndrome develops following oral administration of chlortetracycline or oxytetracycline. When the bacterial flora is markedly suppressed on the third to fourth day, Proteus organisms grow out quite regularly and may cause diarrhea. Should a resistant Micrococcus pyogenes develop that produces a potent enterotoxin, then nausea, vomiting, bloody diarrhea, hyperpyrexia, collapse, and death may result. This simplified diagram cannot present all the possibilities.

postoperative paralytic ileus when nothing can be administered by mouth. The combination of neomycin and phthalylsulfathiazole fulfills these major requirements surprisingly well.

An antibacterial agent that is used solely for intestinal antisepsis is less likely to encounter resistant strains of bacteria because of the lesser likelihood that resistant strains will become common as a result of widespread administration. The field of intestinal antisepsis has developed to where the search is no longer for new intestinal antiseptics but rather for intestinal antiseptics that are superior to those available or for a substance whose use will be restricted to intestinal antisepsis.

ABSORPTION AND EXCRETION OF NEOMYCIN

Studies were conducted to determine to what extent neomycin is absorbed from the gastrointestinal tract of man, what blood levels are maintained, and the rapidity

of excretion of the antibiotic in the urine. Following the oral administration of a single 1 gm. dose of neomycin to a person with a normal gastrointestinal tract, hourly blood specimens were taken for the first six hours and then every four hours thereafter for 48 hours. Ordinarily, no neomycin could be detected in the serum. Occasionally, some antibacterial activity against the spores of Bacillus subtilus could be demonstrated in the undiluted serum. The urine was quantitatively collected until assay of the stools showed that they no longer contained neomycin and then the urine was assayed for neomycin. Excretion by the kidneys averaged 3% of the ingested dose. Blood specimens assayed following a maintenance dose of neomycin of 1 gm. every four hours for three days yielded only slight antibacterial activity.

BACTERICIDAL ACTIVITY OF NEOMYCIN

Aside from the fact that neomycin has only slight activity against Shigella organisms and the fact that in a certain percentage of patients a resistant strain of Aerobacter aerogenes will develop following its oral administration, the bacterial spectrum of this substance makes it particularly suitable as an intestinal antiseptic. No bacteria can be cultured from a 10% suspension of human feces 30 minutes after the addition of neomycin in a concentration of 500 mcg. per milliliter. A concentration of 10,000 mcg. of neomycin per milliliter can be maintained in the gastrointestinal tract of man under therapeutic conditions.

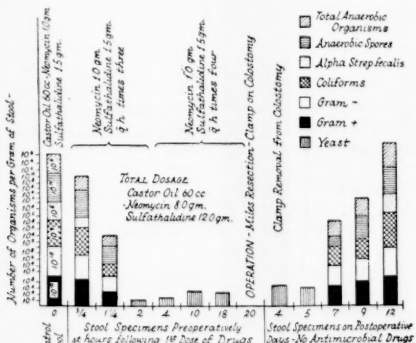
Number of Organisms per Gram of Stool
Total Anaerobic Organisms
Anaerobic Spores
Alpha Strep fecalis
Coliforms
Gram -
Gram +
Yeast
Castor Oil 60cc Neomycin 1.0 gm. Sulfathaladine 1.5 gm.
Neomycin 1.0 gm. Sulfathaladine 1.5 gm. q 4h times four
Neomycin 1.0 gm. Sulfathaladine 1.5 gm. q 4h times four
TOTAL DOSAGE Castor Oil 60 cc Neomycin 8.0 gm. Sulfathaladine 12.0 gm.
OPERATION - Miles Resection - Clamp on Colostomy
Clamp Removal from Colostomy
Control Stool
Stool Specimens Preoperatively at hours following 1st Dose of Drugs
Stool Specimens on Postoperative Days - No Antimicrobial Drugs Since Operation

Fig. 2.—Illustration of the rapid and sustained antimicrobial action following administration of neomycin and phthalylsulfathiazole (Sulfathalidine) to a patient without bowel obstruction preoperatively.

Following these observations, experiments were conducted to determine the degree to which neomycin would protect mice against peritonitis resulting from introduction of a suspension of feces into the peritoneal cavity. Mice weighing 20 gm. were inoculated with 1 ml. of a 10% suspension of human feces. These animals began to die within three hours after inoculation. Almost all of the animals were dead in 12 hours, and none survived at the end of 24 hours. If these animals received intraperitoneally a tolerated dose of neomycin within the first hour after inoculation, however, the survival rate was 100% as contrasted to a mortality of 100% in the untreated animals. The inoculum of feces received by the mice corresponds to 400 gm. or 4,000 cc. of the 10% suspension given to a man weighing 80 kg. It is inconceivable that a person could survive, regardless of any therapeutic procedure, following the introduction of such a large quantity of highly contaminated material with its accompanying foreign matter into the peritoneal cavity.

Even though the findings in the mouse must not be carried over directly to man, these observations give an indication of the efficacy of this antibiotic. It has been repeatedly shown to be impossible to grow bacteria from specimens removed from the bowel at the time of operation 30 minutes after the gastrointestinal tract of man is flooded with a 1% neomycin solution.

STABILITY OF NEOMYCIN IN THE GASTROINTESTINAL TRACT OF MAN

Since neomycin is so poorly absorbed from the gastrointestinal tract, it becomes of interest to determine how long this antibiotic will remain active in this environment (fig. 2). Patients who had undergone abdominoperineal resection of the rectum with the colostomy kept clamped off until the fourth postoperative day were selected for studying the persistence of the bactericidal activity of neomycin in the bowel. These patients had been prepared with neomycin and phthalylsulfathiazole, and just prior to operation no viable organisms could be isolated from the feces. Postoperatively the patients received no antibacterial drugs either by mouth or parenterally. All stools were cultured following the removal of the colostomy clamp. Ordinarily considerable quantities of feces were passed immediately following removal of clamp. Usually no viable bacteria could be cultured from the stool for as long as six to seven days postoperatively. If a primary anastomosis was done, the third postoperative stool usually showed a few organisms and the normal bacterial flora ordinarily reestablished itself in the course of an additional two or three days. There was no growth of bacteria during the period of paralytic ileus.

OUTGROWTH OF YEASTS

It has been observed that yeasts grow out in great numbers when the bacterial population is reduced to low numbers by the antibiotics. The development of bloody diarrhea following the oral administration of chlortetracycline and oxytetracycline was considered to be due to Monilia infection. Considerable doubt is cast on this supposition, however, when it is realized that oral administration of neomycin results in a greater reduction of the bacterial population and a greater outgrowth of yeasts without the development of bloody diarrhea.[19] No complications due to the outgrowth of yeasts have been observed in 526 persons treated with neomycin orally.

These yeasts consist largely of Candida albicans, with occasionally large numbers of Actinomyces being present. The hazard existing because of the presence of these yeasts should not, however, be disregarded as possible causes of rare and bizarre complications. Bacteria hold the growth of yeasts in check, and it would be helpful if a strain of nonpathogenic organisms resistant to the intestinal antiseptic could be maintained in the bowel. The relatively nonpathogenic alpha Streptococcus fe-

calis is not depressed by the sulfonamides, and these organisms effectively suppress the yeasts. No suitable nonpathogenic organism has been found that will continue to grow following the administration of neomycin. No satisfactory means has been found to suppress the yeasts, but there seems to be considerable doubt that yeasts cause complications except in rare instances, possibly in extremely debilitated or moribund persons.

INFLUENCE OF INTESTINAL ANTISEPSIS ON HEALING

Healing of the bowel must not be retarded by intestinal antiseptics either because of their direct contact with the tissues or because of unfavorable secondary influences such as may result from enterotoxins produced by the Micrococcus pyogenes overgrowth that occasionally follows the oral administration of chlortetracycline and oxytetracycline. We have been unable to show any evidence of vitamin K deficiency following the prolonged administration of succinylsulfathiazole, phthalylsulfacetamide, or neomycin. It is conceivable that the clotting mechanism may be altered by the prolonged administration of neomycin and phthalylsulfathiazole and a purified diet such as protein hydrolysate and carbohydrates given either orally or intravenously.

It has been demonstrated experimentally that succinylsulfathiazole, phthalylsulfathiazole, streptomycin, and neomycin do not retard healing.[20] In fact, healing proceeds rapidly and simulates primary tissue repair.

PROPERTIES AND CHARACTERISTICS OF PROPOSED INTESTINAL ANTISEPTICS

Following are brief descriptions and conclusions as to the value of substances that have been proposed as intestinal antiseptics.

Sulfaguanidine.[21]—Sulfaguanidine has very limited antiseptic activity. It is readily inhibited in the presence of ulcerating lesions in the gastrointestinal tract. It is slow in its action, and it is absorbed in appreciable quantities. Sulfathiazole and sulfaguanidine are absorbed about equally from the gastrointestinal tract. It was found that approximately one-fourth of the patients who received sulfaguanidine as an intestinal antiseptic had untoward toxic reactions characteristic of reactions to the sulfonamides. It is not recommended as an intestinal antiseptic.

Succinylsulfathiazole.[22]—Succinylsulfathiazole is not readily absorbed from the gastrointestinal tract. It rather consistently inhibits the growth of gram-negative organisms, which are normal inhabitants of the gastrointestinal tract of man, without evidence of the development of resistance. Untoward reactions characteristic of sulfonamide compounds develop in approximately 1% of the treated patients. Since succinylsulfathiazole is a bacteriostatic agent, it must be administered for approximately seven days before its full effect is obtained. It tends to make the stools soft and aids in the mechanical preparation of the gastrointestinal tract. It is the most satisfactory of the bacteriostatic sulfonamides available as an intestinal antiseptic.

Phthalylsulfathiazole.—Compared to succinylsulfathiazole, phthalylsulfathiazole has very much the same properties. It is approximately twice as effective gram for gram. It has the undesirable property that it tends to cause the stools to have a ropy, tenacious consistency, which makes the evacuation and cleansing of the bowel somewhat difficult. It possesses the advantage over succinylsulfathiazole, however, that it is more effective in the presence of a watery diarrhea. Toxic reactions develop in less than 1% of the treated patients.

Phthalylsulfacetamide. — Phthalylsulfacetamide has much the same properties as succinylsulfathiazole and phthalylsulfathiazole. It is, however, absorbed to a much greater degree than the previous two sulfonamides. The extent of this absorption varies greatly. It can be expected, therefore, to give rise to a relatively larger number of toxic reactions.

Streptomycin.—Streptomycin acts rapidly, removing almost all organisms in 24 to 48 hours of oral administration. This is followed unfortunately by the rapid development of resistant strains within three to four days. This antibiotic is sparingly absorbed from the gastrointestinal tract. Following oral administration, there is no toxicity. It cannot be recommended as an intestinal antiseptic because of the rapid development of resistant strains of organisms. It is of no value in the postoperative paralytic ileus phase.

Chlortetracycline.—Chlortetracycline is a broad spectrum antibiotic with bactericidal properties. It removes bacteria from the gastrointestinal tract moderately rapidly, but unfortunately there is outgrowth of resistant organisms. Micrococcus pyogenes and Proteus organisms appear on about the third or fourth day following suppression of the coliform bacteria. If Proteus organisms grow out first, the Micrococcus pyogenes will be inhibited. Should the Micrococcus pyogenes grow out first, serious complications may result. About 30% of staphylococci are now resistant to chlortetracycline, and some 40% of these organisms produce a potent enterotoxin. This enterotoxin is capable of producing the so-called choleriform syndrome, consisting of vomiting, bloody diarrhea, hyperthemia, and collapse. The course may be rapidly fatal, even though the complication is recognized early and proper treatment is instituted immediately.

Furthermore, the antibiotic is absorbed and not retained in the gastrointestinal tract during the postoperative paralytic phase. It is not recommended as an intestinal antiseptic.

Oxytetracycline.—Oxytetracycline has very much the same properties as chlortetracycline. For the same reason, it is not recommended as an intestinal antiseptic.

Chloramphenicol.—Chloramphenicol has limited activity. Because of its toxic reaction and high degree of absorption from the gastrointestinal tract, it is not recommended as an intestinal antiseptic.

Neomycin.—Neomycin is a broad spectrum antibiotic with bactericidal properties. It is capable of sterilizing the gastrointestinal tract in two to three hours when administered together with castor oil. After contact with feces for 15 minutes in concentrations that are readily maintained in the gastrointestinal tract, no viable bacteria can be isolated. This antibiotic has only limited activity against Shigella organisms. Aerobacter aerogenes grows out in approximately 10% of cases. Neomycin is not recommended as an intestinal antiseptic when used alone.

Neomycin and Phthalylsulfathiazole.—The administration of neomycin and phthalylsulfathiazole combined gives excellent results. The phthalylsulfathiazole inhibits the outgrowth of Aerobacter aerogenes. This combination is undoubtedly the best available material for intestinal antisepsis now available. Action is maintained as long as the drugs are retained in the gastrointestinal tract. Both of these substances are absorbed from the gastroenteric tract to a limited degree.

CLINICAL APPLICATION OF NEOMYCIN AND PHTHALYLSULFATHIAZOLE

Patients can be divided into three groups. The first consists of persons to whom purgatives may be given. Partial obstruction is present in the second group, necessitating more cautious handling and gradual decompression of the bowel. The third group is comprised of patients having acute or complete intestinal obstruction, stab wounds, and gunshot wounds necessitating urgent abdominal exploration. In this group preoperative preparation directed toward decompression of the bowel or alteration of the intestinal flora is not feasible. Following are the outlines of the usual treatment in these three groups:

Group 1.—The complete preparation requires 20 hours in group 1. Measures include a low residue diet. At 1 p. m. 60 cc. of castor oil, 1.0 gm. of neomycin, and 1.5 gm. of phthalylsulfathiazole are given. At 2 p. m., 3 p. m., and 4 p. m. 1.0 gm. of neomycin, and 1.5 gm. of phthalylsulfathiazole are given. At 8 p. m., 12 midnight, 4 a. m., and 8 a. m., or every four hours until operation, 1.0 gm. of neomycin and 1.5 gm. of phthalylsulfathiazole are given. The operation is performed at 9 a. m.

Group 2.—In group 2 the period of preparation is determined by the length of time required to decompress the bowel. No purgation is necessary. Gastric suction is continued until the bowel is decompressed and gas is passed. Neomycin in doses of 1.0 gm. and phthalylsulfathiazole in doses of 1.5 gm. are given for a minimum of 24 hours or until optimal mechanical preparation is obtained.

Group 3.—In group 3 urgent surgical treatment is required as soon as the general condition of the patient warrants. Should it become necessary to resect the bowel, do primary anastomoses, or close large defects in the bowel, decompression is performed transabdominally and the bowel is flooded with 1% neomycin solution. Frequently a liter of solution is injected into the lumen of the small and large bowels. Adults will tolerate the introduction of 2.0 gm. of neomycin into the peritoneal cavity. Neomycin and phthalylsulfathiazole contained in the bowel will continue to be active throughout the period of postoperative paralytic ileus.

COMMENT

Intestinal antisepsis has a definite place in our medical armamentarium. Experimentally it can be shown that the healing of the wound at the line of anastomosis is changed from the secondary healing of an infected contaminated wound to healing that closely resembles primary repair. The experimental demonstration that 50% of animals will survive following ligation of the blood supply to segments of bowel of sufficient length to cause the death of all untreated animals is again strong evidence that removal of pathogenic bacteria from the lumen of the bowel gives considerable protection to tissues with markedly impaired blood supply.

Postoperative peritonitis or disruption of the suture line and fistula formation has not occurred in a single patient under my care since 1941, when succinylsulfathiazole became available. Furthermore, wound infections, especially those caused by the coliform organisms, have become extremely rare, even though open suture of bowel is done regularly.

The open suture method of bowel anastomosis can be done safely following proper application of intestinal antisepsis. This permits more accurate approximation of bowel edges, with less tension, a better blood supply, less edema, and uncomplicated healing.

The temperature seldom rises more than 1 degree F the first day after resection and primary anastomosis of the colon and remains normal thereafter. The entire convalescence is much simplified.

Dixon and Benson [23] showed that, after closure of a colostomy, 80% of wounds healed primarily when the patient was prepared with succinylsulfathiazole as compared to 8% when intestinal antiseptics were not used. Pemberton, Black, and Maino [24] showed a change of mortality due to peritonitis following surgery of the large intestine from 6.1% in 1934-1940 to 1.6% in 1941-1942 and in 1.4% in 1942-1943 after intestinal antisepsis was practiced.

The practice of intestinal antisepsis does not prolong the period of preoperative preparation. As soon as the bowel can be prepared mechanically, it can now be prepared bacteriologically. It does not require so much as an hour's contact of a readily attained and maintained concentration of neomycin with the fecal contents of the bowel to render them essentially sterile. Phthalylsulfathiazole given at the same time will inhibit the outgrowth of Aerobacter aerogenes.

These intestinal antiseptics will remain in the bowel during the period of postoperative ileus and continue their effectiveness. Once bowel evacuations are reestablished, the drugs can be again administered. They need not be given postoperatively except when defects are closed or primary anastomoses of the bowel are performed.

It is most inconvenient that the aspects of intestinal antisepsis are so changeable, as they are in the entire field of antibacterial therapy. What is fact today must be modified tomorrow, because the variables will have changed again. No sooner is an effective antibacterial agent found than a new group of resistant variants appear.

Succinylsulfathiazole, with its slow action and narrow bacterial spectrum, has continued to be an effective intestinal antiseptic against most of the pathogenic organisms in the gastrointestinal tract of man. The use of succinylsulfathiazole is so limited that a widespread evolution of resistant organisms has not occurred. For this reason and because resistant pathogenic organisms have developed following the use of many of the antibiotics, succinylsulfathiazole has remained useful in intestinal antisepsis and may become even more important

V 1
195

if resistant variants of pathogenic organisms develop against such a valuable intestinal antiseptic as neomycin.

Neomycin has continued to be as effective as an intestinal antiseptic in this community as when it was first used in December, 1949. A seasonal variation is noted when dogs are treated. During the hot, humid summer months in Galveston, no substance or combination of substances has been found that will appreciably lower the microbial population of the dog's intestinal tract. There is less tendency toward resistance in man. However, an Aerobacter aerogenes resistant to neomycin was first encountered during the summer of 1950.

A number of hemolytic and nonhemolytic streptococci are fairly resistant to neomycin. Under conditions of preparation of the bowel, the alpha Streptococcus faecalis, the usual inhabitant of human bowel, disappears very promptly and completely and does not reappear during the course of treatment. It is possible that resistant streptococci may eventually be found in certain communities. Attention is called to the fact that bacitracin is highly effective against streptococci, and it is only sparingly absorbed from the bowel. The occasion may arise when it will be desirable to add bacitracin to the combination of neomycin and phthalylsulfathiazole. Also polymyxin B is poorly absorbed from bowel and is quite active against Pseudomonas organisms.

It would be most helpful if the use of an antibiotic such as neomycin could be restricted to intestinal antisepsis. Neomycin ointment is being used rather widely for topical therapy in skin conditions, and it is not unlikely that many resistant variants will soon appear, with the resultant diminution of the value of neomycin as an intestinal antiseptic. In all probability, however, resistance will first become evident following the use of the ointments, and perhaps this widespread topical application will be discontinued before resistant streptococci occur in the bowel.

Chlortetracycline and oxytetracycline have rapidly become useless as intestinal antiseptics because their wide and frequent general use has resulted in 30% of Micrococcus pyogenes being resistant variants. Since 40% of these organisms produce potent enterotoxins, the overgrowth of these organisms in the intestinal tract too frequently establishes the serious complication called the "choleriformic syndrome" following oral administration of chlortetracycline and oxytetracycline.

With these considerations in mind, it is proposed that the use of neomycin be restricted to intestinal antisepsis in combination with phthalylsulfathiazole or other antibacterial agents that are poorly absorbed from the gastrointestinal tract. It may not be amiss to suggest that the A.M.A. Council on Pharmacy and Chemistry make recommendations as to the uses to which various antibiotics should be restricted. Especially the use of these valuable and specific therapeutic agents should be discouraged when they are not absolutely indicated.

CONCLUSIONS

Intestinal antisepsis is worth while. Neomycin and phthalylsulfathiazole (Sulfathalidine) given simultaneously are the best intestinal antiseptics now available.

918 Strand.

COUNCIL ON FOODS AND NUTRITION

WITHDRAWAL OF ACCEPTANCE OF SMA CONCENTRATED LIQUID

The Council on Foods and Nutrition has authorized the publication of the following statement.

JAMES R. WILSON, M.D., *Secretary.*

After thoughtful consideration, the Council on Foods and Nutrition withdrew its acceptance of SMA Concentrated Liquid of the Wyeth Laboratories, Inc., on Oct. 8, 1953. In May, 1953, attention was called to the occurrence of convulsions in certain infants fed on a new formula of SMA Concentrated Liquid. This product was withdrawn from the market and replaced with another formula. However, reports of convulsions were again called to our attention. After this, vitamin B_6 was added to the formula. The evidence thus far available does not satisfy the Council that this simple addition corrects the basic difficulty. The problem needs further study. The Council will be pleased to consider new evidence concerning the acceptability of SMA Concentrated Liquid. SMA Powder remains a Council accepted product.

The following products have been accepted as conforming to the rules of the Council.

JAMES R. WILSON, M.D., *Secretary.*

Heinz Junior Marcaroni and Cheese.

Ingredients: Marcaroni, cheese (cheddar), whole milk powder, cake flour, salt, and water.

Analysis (submitted by manufacturer).—Total solids 14.85%, moisture 85.15%, ash 1.12%, fat (by acid hydrolysis) 2.68%, protein (N × 6.25) 2.95%, crude fiber 0.26%, total sugar as sucrose 1.03%, natural reducing sugar 1.07%, acidity (as lactic) 0.13%, starch 6.64%, and salt 0.79%.

Vitamins and Minerals	Per 100 Gm.
Carotene	25 I. U.
Thiamine	16.5 mcg.
Riboflavin	70 mcg.
Niacin	0.139 mg.
Calcium	78 mg.
Phosphorus	49 mg.
Iron	1.5 mg.
Copper	1.3 mg.

Calories.—0.67 per gram; 19.0 per ounce.

Use.—For use as a transition food for infants from semiliquid foods to adult foods.

Heinz Strained Rice and Cheese.

Ingredients: Cheese (cheddar), rice, wheat flour, cream, whole milk powder, salt, and water.

Analysis (submitted by manufacturer).—Total solids 15.26%, moisture 84.74%, ash 1.06%, fat (by acid hydrolysis) 4.12%, protein (N × 6.25) 2.81%, total sugar as sucrose 0.76%, natural reducing sugar 0.86%, crude fiber 0.06%, acidity (as lactic) 0.11%, starch 6.28%, and salt 0.79%.

Vitamins and Minerals	Per 100 Gm.
Thiamine	14.1 mcg.
Riboflavin	77.0 mcg.
Niacin	0.124 mg.
Calcium	85.0 mg.
Phosphorus	58.0 mg.
Iron	0.29 mg.
Copper	0.043 mg.

Calories.—0.76 per gram; 21.6 per ounce.

Use.—For use as a transition food for infants from milk to semiliquid foods.

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STATE PHYSICIANS PLACEMENT ACTIVITIES

Physicians placement activities by state associations and by the American Medical Association have increased during 1953. This work in the A.M.A. is under the direction of the Council on Medical Service's Committee on Extension of Hospitals and Other Facilities. The committee began the year by stepping up its own work. States have been encouraged by the committee to improve the data on openings, to expand their contacts with sources of physicians, and to work more closely with communities needing a physician. The committee, in turn, has for the first time sought to publicize the services offered to physicians and communities by the A.M.A. and has developed a periodic reporting system for checking on both openings and requests for placements. As a part of this work, two regional conferences were scheduled during the year. The first was held in Memphis, Tenn., in March, the second in Asheville, N. C., in September.

Ten years ago relatively few states offered organized service in this field. Today there are 43 state physician placement services behind the communities seeking adequate medical aid. The amount and form of activity varies with the state but whether or not the state carries on such a program the placement service of the A.M.A. stands ready to assist both communities and physicians. If an active organization exists in the state, the A.M.A. serves as a clearing house, passing on to the states the requests that are received and providing information for physicians who are interested in more than one state.

What is meant by a good physician placement service? The director of the Virginia Council on Health and Medical Care offers this definition: "By a good service I mean one where requests from communities are carefully investigated to establish the need for a doctor; where there is personnel available to meet with community groups to give them the ABC's of getting doctors; where up-to-date information is sent monthly or at least quarterly to communities on available doctors and detailed information to doctors on communities; where periodic follow-up visits are made to communities to encourage them and answer their questions; and where contact is kept with the community and the local doctor to make certain that the new relationship is not spoiled by misunderstandings, and that the doctor, once located, stays."

The service in Virginia, under the direction of Edgar J. Fisher Jr., is making great strides toward alleviating the shortage of doctors in the rural areas. A direct request for guidance must come from an individual or group in the community. When that request is presented, an all-out effort is made toward securing the services needed. Success stories of such communities as Forest, Huddleston, and Montevideo, Va., are a few examples of how a united effort resulted in providing needed medical aid. Money was raised in each of these areas to build a clinic; adequate facilities brought, in some cases, not one doctor but two. According to various physician placement service directors, "a community can have necessary medical care if the citizens want it, are willing to work for it, and have the know-how to get it." Persons are usually willing to work for the things they really want.

The first time a physician is secured by a community a guiding hand may be needed. Those who operate a state placement service know their state—the communities, the medical persons, and the roads—and most of all they have had experience with the problems of obtaining a physician for a community. They are in contact with the medical schools in the area and the hospitals approved for the training of interns and residents; to their office go the letters of physicians who seek a practice in that state. The placement service of the Illinois State Medical Society, under the guiding hand of Harold M. Camp, M.D., puts strong emphasis on the need of a community. Cognizance is taken of the location of the community requesting assistance in securing a physician. Because good roads make distances a small consideration, communities as near as 10 miles to medical facilities are encouraged to use the existing medical aid. Communities are not encouraged to seek a physician when it is apparent that what they really are seeking is a "first aid man." This well-organized service has ample facilities for assisting both communities and physicians. Five class A medical schools, a generous loan fund for training prior to internship, and associated programs, achieved through the Illinois State Medical Society, are additional aids in meeting the medical needs of the state.

In Missouri, Mr. Raymond McIntyre, the field secretary of the state medical association, makes a personal visit to all communities that request assistance in obtaining a physician. His visit is highly valuable to the community; in telling what they have and what they need, the community takes inventory. This may be the first step toward the location of a home and a place to practice for the physician. The prior approval of local medical practitioners is sought before the community is listed as needing an additional practitioner. Such first-hand information facilitates the office work that will follow, when listings are sent to the physicians and when the inquiring physicians visit the office.

Most placement services put strong emphasis on personal contact, both with the physician and, where personnel permits, with the community. Written records of this information are highly important; mental files are

V 1
195

lost for all practical purposes when a change in personnel occurs. In consulting such placement services as those in Texas, Ohio, Michigan, North Carolina, New York, and Virginia, it can be seen that much of their success can be attributed to the complete and up-to-date file systems. Placement service is for the assistance of communities seeking a physician; a physician seeking an assistant; an industry, college, institution, or public health group seeking a physician; and those seeking the services of a specialist, which means this service is available to the physicians seeking such openings. During the past year the state-operated physician placement services have handled requests from more than 2,700 physicians seeking a location. Since some physicians make inquiry in more than one state, duplications occur in this figure. In addition, 702 communities have sought the aid of these services. A strong placement service under the state medical association is visible proof that organized medicine is making an effort to help persons help themselves to adequate medical care.

RESECTION OF ANEURYSMS OF ABDOMINAL AORTA AND RESTORATION OF CONTINUITY WITH HOMOGRAFT

DeBakey and Cooley [1] point out that the survival period in cases of aortic aneurysms is relatively short, ranging from six months to two years in well over half of the patients, with only a few patients living more than several years after the onset of symptoms or establishment of diagnosis. The various attempts to treat aortic aneurysms in the past, whether by an attempt to promote thrombosis and fibrotic organization, by introduction of foreign material into it, or by the wrapping method to encourage periarterial fibroblastic reaction, have not given encouraging results. Extirpation of the aneurysm with restoration of blood flow appeared as the only logical surgical therapy in these cases.

Gross and his associates,[2] in their extensive experimentation with arterial grafts in dogs, advanced the principle that a satisfactory solution to the problem of bridging a gap in large arteries or in the aorta would lie in the direction of providing a vascular graft that would be viable, would resemble the normal vessel after implantation, could withstand intra-arterial pressures, would not cause thrombosis, and would not set up serious reaction in the original tissues. Experiments by Carrel and by Guthrie had demonstrated that transplantation of fresh arterial grafts from one animal to another had shown degrees of survival. Three main factors, according to Gross, that might influence the success or failure of an arterial graft, were (1) the viability of the vessel at the time of implantation, (2) the degree of immunological reaction between the host and the graft, and (3) the technique employed in making the anastomosis.

After much experimentation, Gross and associates developed a method for the preservation of arterial segments. This consists of storage of vessels in temperatures just above freezing (1 to 4 C) and immersing them in a mixture of 10% homologous serum in a balanced salt solution to which were added a buffer, a pH color indicator, and streptomycin and penicillin. Vessels to be stored have been removed from donor animals between one and four hours after death and have been kept as long as 42 days before they were successfully transplanted into other dogs. Tissue culture studies have shown that viability is maintained for 35 to 40 days in blood vessels stored in this manner. Segments of arteries or aortas have been secured from persons who have died suddenly without sepsis. These vessels have been stored in the manner described and have subsequently been used for human patients, when the need arose, to bridge gaps in large arteries. Segments of such preserved arteries or aortas have been grafted by Gross and his associates into human subjects, with promising results.

In 1951 Dubost [3] reported a case of abdominal aneurysm in which the aneurysm extended from below the origin of the renal arteries downward to involve the aortic bifurcation. He resected the aneurysm and reestablished the continuity of the aorta by utilizing a graft of human aorta preserved for 15 days in the medium as suggested by Gross. An end-to-end anastomosis was performed; the left common iliac and the left hypogastric arteries were sectioned; and the left common iliac was anastomosed to the graft by an end-to-side anastomosis. Three weeks later the patient was able to walk and had excellent pulsation in both legs.

DeBakey and Cooley report, in a recent communication,[1] on seven patients in whom aortic aneurysm was resected and the normal blood flow was restored by means of an aortic homograft. The aneurysm in six patients was of arteriosclerotic origin and in one of syphilitic origin. The aneurysms were all located in the segment of the aorta below the origin of the renal arteries. The age of the patients ranged from 47 to 74 years. There was one death in this series. The rest of the patients tolerated the operation well and have shown excellent early results. These authors also report on five additional cases in which the same procedure was performed with no fatalities and no complications. The aneurysms were all of arteriosclerotic origin and involved the bifurcation, which therefore had to be resected. Anticoagulants have not been used in these operations. The period of aortic occlusion varied from 48 to 102 minutes. The anastomotic procedure was found to be technically feasible in all of their cases despite rather extensive atheromatous changes in some. Even though the immediate results of the resection of these aneurysms were highly successful, it is perhaps much too early to predict the ultimate results.

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2. Gross, R. E.; Bill, A. H., Jr., and Peirce, E. C., II: Methods for Preservation and Transplantation of Arterial Grafts: Observations on Arterial Grafts in Dogs: Report of Transplantation of Preserved Arterial Grafts in 9 Human Cases, Surg., Gynec. & Obst. **88**: 689-701 (June) 1949.

3. Dubost, C.; Allary, M., and Oeconomos, N.: A Propos du traitement des anévrysmes de l'aorte: Ablation de l'anévrysme: Rétablissement de la continuité par greffe d'aorte humaine conservée, Mém. Acad. chir. **77**: 381-383 (April 11-18) 1951.

THE EFFECT OF ISONIAZID ON THE EMOTIONS

Because there has been some controversy regarding the effect of isoniazid on the emotions of tuberculous patients, an examination of the available facts is in order. According to one of the earlier reports [1] the apathy and drowsiness characteristically seen among many of the acutely ill tuberculous patients were completely eliminated by the second week of treatment in all instances. Some of these patients even became disciplinary problems before any objective signs of improvement could be noted. These and other workers published reports in which similar observations were made, but this aspect of treatment with isoniazid was not confirmed in a later report.[2]

The attitudes and emotional reactions of the patients are important factors in the treatment of tuberculosis, as was recognized by Osler, who said, "It is just as important to know what is in a man's head as what is in his chest if you want to predict the outcome of his pulmonary tuberculosis." For this reason Calden [3] set about to evaluate the attitudes of tuberculous patients and concluded that the sentence completion method, a projective technique widely used by clinical psychologists in a variety of hospital settings, modified to fit this group of patients, was highly valid.

Lorenz and co-workers [4] in an effort to reach a definite conclusion regarding the effect of isoniazid on the emotions of tuberculous patients studied 15 male patients selected at random before isoniazid treatment was started by obtaining (1) an introspective statement by the patient estimating his own mood and state of well-being; (2) a clinical evaluation of his emotional state by a trained observer; (3) an evaluation of his mood and attitude by psychological testing; and (4) a pain threshold determination.

The psychological tests included the Guilford inventory, which "has been shown to be an adequate indication of the extent to which a person is depressed or cheerful, introverted or extroverted, happy-go-lucky or serious-minded, and flighty or stable," and 5 of the 80 sentences in the Madison Sentence Completion Form: (1) The future looks . . .; (2) The chances of my getting better . . . ; (3) Ten years from now . . .; (4) I feel I am getting . . .; and (5) The longer I remain in bed . . . After two or three weeks of treatment the four indexes of emotional status were reapplied. Neither consistent nor significant emotional changes were found, and none of the patients became euphoric. This confirms the later reports, suggests that the elation observed in earlier patients was a reflection of indirect psychological factors, and demonstrates again the need for objective testing and cautious interpretation of findings especially when observing the effects of a new drug.

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2. Quarterly progress report of the VA-Army-Navy study on the chemotherapy of tuberculosis, Oct., 1952.

3. Calden, G.: A Method for Evaluating the Attitudes of Tuberculous Patients, Am. Rev. Tuberc. **67**: 722-731, 1953.

4. Lorenz, T. H.; Calden, G., and Ousley, J. L.: A Study of the Effects of Isoniazid on the Emotions of Tuberculous Patients, Am. Rev. Tuberc **68**: 523-534, 1953.

SYNTHESIS OF PITUITARY HORMONES

Du Vigneaud and his associates working at Cornell University have announced the total synthesis of the oxytocic hormone of the neurohypophysis.[1] This achievement is particularly significant in that it represents the first reported synthesis of a polypeptide hormone. In a recent editorial in THE JOURNAL,[2] attention was drawn to the remarkable advances made by this group of workers in the purification and identification of the oxytocic and pressor hormones. They established that the oxytocic hormone consisted of one equivalent each of eight amino acids and three equivalents of ammonia, and on the basis of various physical properties and chemical reactivities of the highly purified natural hormone they deduced the probable chemical structure. Despite the extreme technical difficulties that beset work of this nature, they succeeded in synthetizing this compound, which has proved to be virtually identical with the natural oxytocin in regard to biological activity and chemical and physical properties.

In parallel studies,[3] du Vigneaud and his associates have postulated a structural formula for vasopressin that they had previously shown to differ from oxytocin in that leucine and isoleucine were replaced by phenylalanine and arginine or phenylalanine and lysine, depending on whether the active principle was isolated from beef or hog glands.[4] They have prepared an octapeptide with a structure corresponding to that proposed for lysine-vasopressin, and their preliminary studies indicate that this compound possesses both pressor and antidiuretic activity.

The natural corollary of these studies will be the synthesis of closely related compounds so that the effect of structural changes on biological properties can be studied, with the ultimate expectation that the limitations of the natural products in clinical use may be overcome. The fact that there is apparently a fundamental difference between vasopressin from hog and beef pituitary glands suggests that considerable modification of the molecule may exist without loss of biological activity. Furthermore, if this difference is confirmed, it will represent an interesting example of hormonal species difference that may account for the clinical observation that sensitivity to posterior pituitary injections is apparently occasionally overcome by switching to another commercial preparation.

1. du Vigneaud, V., and others: The Synthesis of an Octapeptide Amide with the Hormonal Activity of Oxytocin, J. Am. Chem. Soc. **75**: 4879, 1953.

2. The Posterior Pituitary Hormones, editorial, J. A. M. A. **161**:914 (March 14) 1953.

3. du Vigneaud, V.; Lawler, H. C., and Popenoe, E. A.: Enzymatic Cleavage of Glycinamide from Vasopressin and a Proposed Structure for This Pressor-Antidiuretic Hormone of the Posterior Pituitary, J. Am. Chem. Soc. **75**:4880, 1953.

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V 15
1951

THE PRESIDENT'S PAGE

A MONTHLY MESSAGE

The end of an old year and the beginning of a new one is both a sad and a happy time. It is an occasion for reflection on what might have been and resolution to do better in the future. It is also a time for taking count of our blessings. We in American medicine have much to be thankful for, although as individuals we might have innumerable complaints. This fact was brought home to me once more as I attended the Board meetings and House sessions in St. Louis earlier this month and walked through the aisles of exhibits at Keil Auditorium. Here were assembled nearly 3,000 doctors who took time from their practices to seek additional scientific knowledge for the benefit of their patients. And these men were there because they *wanted* to attend the A. M. A. Clinical Meeting, not because someone had *decreed* that they should.

My only regret is that there were not more physicians at the session. There is much of scientific value to be gained at these clinical meetings, and the doctors of America are afforded a splendid opportunity to demonstrate the efficacy of free medical enterprise and their interest therein.

In addition to the purely scientific aspects of the St. Louis meeting, there were important actions by the A. M. A. House of Delegates on social security, voluntary health insurance, medical ethics, medical education, hospital accreditation, military affairs, and a wide variety of other subjects affecting both physicians and the public. A detailed account of these actions will be found in another section of THE JOURNAL. I hope that every physician who reads this page will make it his business to familiarize himself with the details.

That brings me right up to what would be the number one item on the list if I were asked to suggest some New Year's resolutions for doctors: "Know your local and state medical societies and their activities. Then make yourself just as thoroughly acquainted with the activities and the policies of the A. M. A."

It is a source of constant wonderment to me that so many physicians are so utterly devoid of knowledge of the policies of the A. M. A. and their local and state medical societies. And I dare say that only a minority of doctors could enumerate the many good acts of public service being performed by their medical organizations.

Make the test yourself sometime. Ask a fellow physician if he can tell you what connection the American Medical Education Foundation has with the A. M. A. and your county and state medical societies. Or have him explain to you the action that was taken by the A. M. A. House of Delegates in June of this year relative to medical care for war veterans.

Frankly, I am chagrined with statements that begin: "Why doesn't the A. M. A. do this . . .?" Or, "Why must the A. M. A. do that . . .?" Actually the A. M. A., as represented by the officials you elect or hire, cannot do anything until you have designated your desires in the meetings of your local or state medical societies. *You* are the A. M. A.

Surely this lack of knowledge of which I speak is not due to a shortage of information. There are scores of medical journals published by county and state medical societies and by the A. M. A. And from the national headquarters of your association there flows a steady stream of printed booklets, brochures, stuffers, newsletters, mimeographed correspondence, and individual replies to an endless chain of special queries. Besides the printed or written word, there are available tape recordings, motion pictures, and film reproductions of television shows that tell the story of organized medicine. Supplementing all of these sources of information are the speakers who travel the length and breadth of the land telling the story of American medicine's service in the public interest.

Maybe I am barking up the wrong tree, but the only answer I can find to the riddle of why there are so many uninformed doctors is that a successful method of communicating ideas to the individual physician has not yet been devised either by his local and state societies or by the A. M. A. No one has yet worked out a sure-fire system of getting the busy doctor to read his medical journals or to look at the mail from the medical groups to which he belongs.

I am hopeful that what I have written here may help stir up some ideas on how to solve this problem. But, until a solution is found, I beg some consideration for my humble suggestion that individual physicians resolve to make it their business to become acquainted with what organized medicine is doing not only for the general public but for the doctor as well.

It is my sincerest wish that the year 1954 will bring to you and every member of your family the blessings of happiness, good health, and a full measure of the good things that we all desire for our loved ones. Above all I pray that God shall bring to the world—and thus to our lasting benefit—a real and permanent peace.

EDWARD J. MCCORMICK, M.D.
Toledo, Ohio

ORGANIZATION SECTION

ABSTRACT OF PROCEEDINGS OF THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION AT THE CLINICAL MEETING IN ST. LOUIS, DEC. 1-4, 1953

The actions of the House of Delegates at the St. Louis Meeting are herewith abstracted so that the readers may have this information in digest form. The official proceedings will be made available, as in the past, in a booklet, which will be sent to all members of the House of Delegates and officers of the American Medical Association by the Secretary. This booklet will not be available for several weeks.—ED.

Invocation

The Right Reverend Arthur C. Lichtenberger, Bishop of the Episcopal Diocese of Missouri, pronounced the following invocation:

Let us pray. Almighty God, who art the giver of light and health, who knowest how the sick have need of a physician, sanctify, we pray Thee, those whom Thou hast called to study and practice the art of healing and the prevention of disease and pain. Strengthen them in soul and body and grant that they may learn their art in dependence upon Thee, and practice it always under Thy sanction and to Thy glory. Strengthen them in body and soul. Give them wisdom and skill, sympathy and patience. And we pray, O Lord, that Thou wouldst govern in their deliberations these delegates here assembled with Thy purpose, illumine their minds with understanding and insight, that in all their decisions they may further Thy purpose for mankind. We ask it in the name of Jesus Christ, our Lord and Savior. Amen.

Preliminary Report of Reference Committee on Credentials

Dr. Walter E. Vest, Chairman, reported that 149 delegates had been seated and that there were a few others whose credentials were not in order but who would be seated later. The Speaker announced that a quorum was present.

Roll Call

The Speaker called the roll of the House, and 177 delegates were recorded as present.

General Practitioner of the Year

Dr. Dwight H. Murray, Chairman, Board of Trustees, presented the following announcement:

It is my pleasure to present the name of the general practitioner who has been selected for the annual award of the American Medical Association of General Practitioner of the Year. He is Dr. Joseph I. Greenwell of New Haven, Ky., 80-year-old active practitioner, who was born in Balltown, Ky., Nov. 27, 1873. He was educated in the Nelson County, Kentucky, public schools; at Cecilia College, from which he received his B.A. and M.A. degrees, and at the Louisville Hospital College of Medicine, from which he obtained his M.D. degree in 1900. For the last 53 years, Dr. Greenwell has practiced in Nelson, Hardin, LaRue, and Marion counties, mostly within a 25 mile radius of New Haven, where he has maintained his office throughout this period. He has been acting health officer for Nelson County for the last eight years and is a consulting physician for the Louisville and Nashville Railroad, and Gethsemane Abbey. During World War II he served four years as examining physician for the Nelson County Selective Service Board.

Perhaps the greatest source of professional pride for Dr. Greenwell has been the babies he has delivered, almost 4,300. Of these, more than 80 were born this year. These deliveries have taken place in everything from log cabins to the modern facilities of the new Flaget Memorial Hospital, Bardstown, which the doctor now uses almost exclusively.

Second only to the immediate welfare of his patients, Dr. Greenwell's greatest interest has been furtherance of the medical profession. He has been active at state, district, and county levels. Until his resignation this year, he served for 30 years as councillor for the fourth district of the Kentucky State Medical Association. He is a past president of the Nelson County and Muldraugh Hill Medical societies, and a member of the American, Kentucky State, and Southern medical associations. Dr. Greenwell has also been active in community affairs. He served 25 years as a member of the New Haven board of trustees and 14 years as mayor. Under his administration as mayor, townspeople saw the construction of New Haven's first sidewalks, the installation of street lights, and the erection of a public water works. He is a director and vice president of the Bank of New Haven. Dr. Greenwell and Miss Marie M. Rapier were united in marriage Nov. 25, 1903, and to this union were born 12 children. Eight are living. Two sons were lost during World War II, one being killed in action. Mrs. Greenwell died in May, 1950. The Board of Trustees is proud of a profession which can produce men of the caliber of Dr. Greenwell.

Adoption of Minutes of New York Annual Meeting

The minutes of the annual meeting held in New York, June 1 to 5, 1953, were adopted as printed and distributed to the members of the House of Delegates.

Report of Reference Committee on Rules and Order of Business

Dr. Joseph B. Copeland, Chairman, presented the following report, which was adopted:

Your Reference Committee on Rules and Order of Business recommends the following: (1) that the order of business be as published in the Handbook, with permission given to the Speaker to make any necessary adjustments unless there is objection from the House at that time; (2) that the Speaker, or, at his request, the President or the Chairman of the Board of Trustees, be granted permission to introduce to the House for an address persons who can give the members of the House pertinent or timely information; and (3) that the Speaker recess the House for lunch at a time to be determined by him.

Presentation of Medal to General Practitioner of the Year

Dr. Edward J. McCormick, President, presented the General Practitioner Gold Medal Award to Dr. Joseph I. Greenwell, New Haven, Ky., who accepted it with the following remarks:

Mr. Speaker, Members of the House of Delegates: I know that this house has many pressing and important matters before it, so I shall express my thanks for this great honor as briefly as possible. Needless to say, I am deeply moved by the honor that you have conferred on me.

We in Kentucky have always been proud of the fact that our state has provided the American Medical Association with more presidents than any other. Because of this, I feel especially honored to be the first Kentucky general practitioner to receive this award. While I am happy to have been singled out as the individual to receive this award, I cannot help but feel that in reality I am but a representative of Kentucky's medical profession. It has been my privilege to know well

V 1
195

many of Kentucky's doctors and they are fine men devoted to service to their patients. There are many of them who are truly outstanding physicians. Today I am merely representing them. Again I want to thank you for this honor. It is the greatest in my life.

Remarks of the Speaker, Dr. James R. Reuling

The Speaker presented the following remarks, which were referred to the Reference Committee on Reports of Officers:

Members of the House of Delegates of the American Medical Association:

That there is much serious work for this and subsequent houses to do, there can be no doubt. In the opinion of your Speaker, things are not going too well. He believes times are just as troubled as they were when we had blanket bills before Congress which would have socialized the practice of medicine. There is a war of attrition going on. The socializers are not dead. They are still at work but taking little bites, nibbles here and nibbles there; we must all be alert to the change in tactics. There were over 259 bills introduced into the last Congress dealing with medicine and health, or having welfare implications affecting medicine, and from all indications this number will be exceeded in the coming session.

To touch on some of the problems that confront American medicine today and to mention only a few, we have non-service-connected disability; dependent medical care; government subsidy in many, many fields—to education, both pre-medical and medical; government subsidy to hospitals; proposed government subsidy to students; Veterans Administration medical education and training progress; health and welfare agencies galore; the doctor draft; state aid; and civilian medical care.

Listen to reports carefully. You would all be surprised and astounded if you knew the hours of work and conferences, the study, the research and writing that go into the reports which are presented to you; the miles the President, the President-Elect, and the Trustees travel, as well as some of the members of this House and numerous members of the Association who serve on councils, bureaus, and committees.

You always do give reports careful attention, for as this speaker has said many times before, he has the greatest respect for the combined judgment of this body. You always come up with the right answers, which proves that you listen carefully. But now more than ever, it is necessary for you to listen, digest, and assimilate even more carefully than usual, for each and every one of you must be a missionary. When all of the reports have been heard and you have voted on the last proposition before this House is adjourned, your work as a delegate is not done. Your labors really at that point have only just begun, for, if we are to be effective, each and every one of us must be a missionary in our own community and in our own state to carry back to the grass roots the story, the problems, and the possible solutions to the problems, not only in improving the health and care of our citizens but also to protect them from the "well-doers." If the socializers are to be stopped, if we are to prevent bureaucratic control in Washington from making inroads into our lives and the lives of all of our citizens, if we are to keep medicine from being fettered, the responsibility lies on each and every one of us.

For years after this country was founded, one of the elements which made it strong was the habit of mutual assistance—neighbors giving aid to those less fortunate, community responsibility, not bureaucratic control, and aid at the local level, not someone at the top giving orders. The doctor at the local level has always been a key figure in community responsibility. The Fabian doctrine says control medicine and you can socialize everything else. There are a few in the profession who say "Why doesn't the county medical society or the state medical society or the American Medical Association do something about it?" That individual is very apt to be one who has lost his own personal sense of individual responsibility.

We have standing rules of the House that are procedural matters that should not be in the Bylaws. Your Speaker recommends that the House consider and adopt a standing rule of procedure that resolutions be in the hands of the secretary at least 48 hours prior to the meeting of the House. If such a rule is adopted, the exceptions presented in the Bylaws, that is, those originating in sections and those relating to business of an urgent nature, would still prevail. What would be the purpose of such a standing rule? There are several that are quite obvious that I have touched on in a letter sent to each of you recently.

1. It will give an opportunity to study the material and make more accurate references. 2. Resolutions can be numbered serially so that all of the delegates can identify them readily. 3. The resolutions can be published "by titles only" in the Daily Bulletin together with the names of the reference committees to which they are assigned. This will not only give the delegates accurate information, but members of the Association at the meeting will have an opportunity to appear before a reference committee in matters in which they are interested. 4. If resolutions have any implications that might lead to bad public relations or unfavorable press relations, such stigma can be eliminated or reduced by having the opportunity of discussing the resolution in advance of introduction. 5. The resolutions can be multigraphed in advance at headquarters, thereby taking much of the load off our small office staff at the time of the session. I would recommend that the reference committee give this matter serious consideration so that we may minimize such baseless and absurd articles as appeared after our last meeting under the title "Watch It Doc."

At the last meeting, there was unfortunate wording in a resolution introduced. The intent would have been clear to a first year high school student. The unfortunate wording would have been picked up had we had time to see the resolution in advance, and finally the action of the House could not possibly have had any such interpretation as appeared in the press. It occurred only because a copy of that resolution was left lying around and was picked up before the reference committee met, before any hearing had been held, before the reference committee wrote its report, and before the House had taken any action.

At this point, your attention is called to the mimeographed copies of resolutions that have been made in order to make your work easier. This was a new procedure at the last meeting, and I want to emphasize and stress a point which might be overlooked. The copies of these resolutions should be considered "confidential material." No copies are to be given to anyone. They should be confidential because until they are introduced and referred and until the reference committee has had hearings and has drawn up its report and finally until the House has voted on that report, all resolutions are quite rightly the opinion of the introducer or a small segment of the profession. Resolutions introduced do not constitute any action, opinion, or policy of the American Medical Association. To let your copies lie around loose where they might be picked up by someone prior to action having been taken would, to say the least, be a violation of good taste.

Your speaker would call attention to the necessity of your signing attendance slips each day for sessions of the House. These are necessary for several reasons: first, for the proper records at headquarters; secondly, that due credit be given for your presence in the published report of the proceedings; and finally there are some state associations that require attendance at all sessions in order that their delegates may be reimbursed for their expenses.

There are two reference committees which seldom have a large volume of material referred for their consideration: The Reference Committee on Hygiene and Public Health, "to which shall be referred all matters relating to hygiene and public health," and the Reference Committee on Industrial Health, "to which shall be referred all matters relating to workmen's compensation and those phases of medical care, including rehabilitation and public health administration, which affect the worker." It is your Speaker's opinion that these might well be combined into one reference committee and it is so recommended.

There are times when the Reference Committee on Miscellaneous Business is literally snowed under. The suggestion is

made that we have two such committees, Miscellaneous Business A and Miscellaneous Business B, to which shall be referred alternately all other business not allocated to any of the enumerated committees or additional committees appointed pursuant to chapter XII, section 1, of the Bylaws. This is only a suggestion, and your speaker would recommend that the suggestion be referred to the Council on Constitution and Bylaws with such comment as the Reference Committee on Reports of Officers may wish to make.

The suggestion has been made by several that we have blackboards set up in each reference committee meeting room and that the chairman of each committee list thereon the material that his committee will hear and act on and also the hour at which each resolution will be heard. The suggestions are excellent except for one thing—time. It is the belief of your speaker that the publication in the Daily Bulletin may care for a part of this suggestion. However, the listing of the time at which a reference committee will hear a certain resolution is not realistic. If any of the chairmen at this meeting are able to do it, more power to them. If the committee to whom this report is referred can come up with any ideas or suggestions, fine. Your Speaker has been a member and has been chairman of reference committees. Time after time things that seemed controversial and might take two hours have been settled in five minutes. Contrariwise, a resolution that appeared on the surface to be perfectly innocuous had innumerable individuals who wanted to be heard and has taken hours to settle.

Report of Reference Committee on Reports of Officers

Dr. George M. Fister, Chairman, presented the following report, which was adopted:

Speaker James R. Reuling began his address at the Clinical Meeting on Dec. 1, 1953, with the timely warning that the struggle against socialization and compulsion of American medicine had not diminished. Methods and tactics have changed and we must be alert. He enumerated many of the problems confronting us. Your committee wishes to emphasize the wisdom of his suggestion that when meetings are completed, the work of a delegate has only begun. It is the missionary duty of a delegate to take back to, and discuss with, his colleagues the problems presented to the House and the conclusions reached for their solution. In order to implement this recommendation, your committee suggests that a résumé of the proceedings of the House be distributed by state or county societies to all members of the American Medical Association under their jurisdiction.

Speaker Reuling suggested important changes in procedure with a view to facilitating the business of the House. He recommended that, as nearly as possible, resolutions be in the possession of the Secretary 48 hours prior to the first meeting of the House. Your committee favors the adoption of this recommendation in the belief that such a procedure will disseminate information regarding resolutions and permit mimeographing, numbering, and leisure study. It is understood, however, that, as in the past, resolutions may be presented during sessions of the House. Your committee recommends that mimeographed, numbered copies of all resolutions be made available to delegates and that delegates consider the contents of resolutions confidential until the House has disposed of them. The Speaker called attention to the advisability of signing attendance slips. This is necessary in order that proper records may be compiled.

It was recommended that the Reference Committee on Hygiene and Public Health and the Reference Committee on Industrial Health be merged into one committee. Your committee approves this recommendation in principle, but believes it is a matter for action by the House.

Speaker Reuling requested opinions as to procedure in appearing at meetings of reference committees. It is suggested by your reference committee that members desiring to discuss certain subjects contact the chairmen of the reference committees involved and arrange a definite time for their appearance.

Reference Committees, Tellers, and Sergeants-at-Arms

Dr. James R. Reuling, Speaker, announced the appointment of Reference Committees, Tellers, and Sergeants-at-Arms, as follows:

Amendments to the Constitution and Bylaws

WILLIAM L. BENEDICT, *Chairman,* Section on Ophthalmology
FRANK J. ELIAS, Minnesota
CHARLES L. FARRELL, Rhode Island
WILLIAM M. SKIPP, Ohio
DEERING G. SMITH, New Hampshire

Board of Trustees and Secretary, Reports of

JOHN J. MASTERSON, *Chairman,* New York
JAMES Q. GRAVES, Louisiana
GORDON F. HARKNESS, Section on Laryngology, Otology, and Rhinology
L. HOWARD SCHRIVER, Ohio
NORMAN A. WELCH, Massachusetts

Credentials

WALTER E. VEST, *Chairman,* West Virginia
VINCENT W. ARCHER, Virginia
THOMAS M. D'ANGELO, New York
HARLAN ENGLISH, Illinois
JAMES P. HAMMOND, Vermont

Executive Session

JOSEPH D. MCCARTHY, *Chairman,* Nebraska
REUBEN B. CHRISMAN JR., Florida
LAWRENCE R. DAME, Massachusetts
JOHN S. DETAR, Michigan
PETER M. MURRAY, New York

Hygiene and Public Health

THURMAN B. GIVAN, *Chairman,* New York
JAY J. CRANE, Section on Urology
WILLIAM L. ESTES JR., Pennsylvania
HOYT B. WOOLLEY, Idaho
STANLEY B. WELD, Connecticut

Industrial Health

FRANK A. MACDONALD, *Chairman,* California
WILLIAM R. BROOKSHER, Arkansas
JAMES STEVENSON, Oklahoma
WILLIAM WESTON JR., South Carolina
DEXTER H. WITTE, Wisconsin

Insurance and Medical Service

JOHN M. PORTER, *Chairman,* Kansas
EUSTACE A. ALLEN, Georgia
HENRY S. RUTH, Section on Anesthesiology
ROBERT B. WOOD, Tennessee
WILLARD A. WRIGHT, North Dakota

Legislation and Public Relations

BRUCE UNDERWOOD, *Chairman,* Kentucky
R. B. HOMAN JR., Texas
J. STANLEY KENNEY, New York
H. KENNETH SCATLIFF, Illinois
C. F. STROSNIDER, North Carolina

Medical Education and Hospitals

JAMES Z. APPEL, *Chairman,* Pennsylvania
WARDE B. ALLAN, Maryland
WARREN W. FUREY, Illinois
CHARLES T. STONE SR., Section on Internal Medicine
LEWIS A. ALESEN, California

Medical Military Affairs

WILLIAM A. HYLAND, *Chairman,* Michigan
H. RUSSELL BROWN, South Dakota
DONALD C. CONZETT, Iowa
J. LAFE LUDWIG, California
WENDELL C. STOVER, Indiana

V 1
195

Miscellaneous Business

H. GORDON MACLEAN, *Chairman,* California
J. WALLACE HURFF, New Jersey
HAROLD B. GARDNER, Pennsylvania
TRUMAN C. TERRELL, Texas
MARTYN A. VICKERS, Maine

Reports of Officers

GEORGE M. FISTER, *Chairman,* Utah
MAURICE J. DATTELBAUM, New York
J. PAUL JONES, Alabama
WILLIAM H. HALLEY, Colorado
GEORGE A. WOODHOUSE, Ohio

Rules and Order of Business

JOSEPH B. COPELAND, *Chairman,* Texas
HERBERT H. BAUCKUS, New York
WILLIAM W. BAUM, Oregon
EDWARD L. COMPERE, Section on Orthopedic Surgery
O. J. CAMPBELL, Minnesota

Sections and Section Work

JESSE D. HAMER, *Chairman,* Arizona
W. ANDREW BUNTEN, Wyoming
RAYMOND F. PETERSON, Montana
J. MATHER PFEIFFENBERGER, Illinois
ALVIA G. YOUNG, Washington

Tellers

CARRINGTON WILLIAMS SR., *Chairman,* Virginia
WILLIAM F. BRENNAN, Pennsylvania
RAYMOND T. HOLDEN, District of Columbia
WESLEY W. HALL, Nevada
ROLLA B. WRAY, Missouri

Sergeants-at-Arms

LOUIS W. JONES, *Master Sergeant,* Pennsylvania
JOHN F. LUCAS, Mississippi
KARL R. RUDDELL, Indiana

Address of the President, Dr. Edward J. McCormick

Dr. Edward J. McCormick, President, presented the following address, which was referred to the Reference Committee on Reports of Officers:

Mr. Speaker and Members of the House of Delegates:

During the meeting of the House of Delegates in New York in June, 1953, I brought to your attention certain activities and problems of American Medicine. I mentioned the distribution of doctors, the 24-hour emergency call service offered by more than 600 county medical societies, and the necessity of fearless grievance and mediation committees in each county and state society. I spoke to you of physician-hospital relationships and of the necessity for continued expansion of voluntary health insurance plans. I encouraged physicians to take part as leaders in the activities of service clubs, fraternal associations, parent-teacher groups, church associations, and others. I made reference to our relationship with the representatives of the press, radio, and television. I asked for unity within the profession.

Since the June meeting of the American Medical Association, countless hours have been spent on planes and trains and in meetings, and I come now to give you the impressions gained during these weeks and months as your President and spokesman.

I am happy to report that progress has been made in the development and implementation of the nine major points which I brought to your attention in New York in June, 1953. However, I would be derelict in my duty and unfaithful to the oath of my office if I did not point out some of our failures.

You cannot have an understanding of medicine's problems unless you meet the press, the people and patients, doctors, and industrialists, and executives on a wide base of transcontinental travel and multiplicity of contacts at all levels. I once believed that after all my years of experience in medical circles at county, state, and national levels, I was well-qualified for the honor which you bestowed on me. However, I soon discovered, and I presume so did many who came into this high office before me, that I had much to learn despite all of my previous experience. And what have I learned in the past six months that would be of interest to this House of Delegates?

First and uppermost is the fact that our relations with the public are not good. Since the Oath of Hippocrates was written, five centuries before Christ, there have been fewer "crooks" in medicine than in any other group with the exception of the ministry, and I say this without reservation or qualification! Yet, as I make this statement, I feel that it is necessary for you, as representatives of your state medical associations, to return to your home and campaign for stronger grievance committees and the expulsion of those who disregard the Principles of Medical Ethics.

Please understand that I am diametrically opposed to a program of national publicity emphasizing the defects of a small number of doctors and heaping on the great percentage of honest physicians and surgeons, who work 12 to 18 hours a day, the sins of a few. But we cannot close our minds to the need for some action that would restore the full confidence of the public in our profession. I have come to the conclusion that bad public relations is a "grass roots" problem and cannot be solved at the national level. Good public opinion cannot be bought. It must be earned through exemplary conduct and genuine service in the public interest. Whatever money the American Medical Association and its constituent societies spend for public education and public relations is wasted unless individual physicians take wholehearted interest in assuring the success of these ventures.

Doctors must know more of public thinking regarding fees and physician-patient relationship if we are to continue to exist as free scientists and practitioners. The thousands of letters which I have received and which come to the headquarters office, plus derogatory articles in the press and magazines, leave little room for argument. We have a policing job to do, and it must be done through the medium of existing disciplinary machinery. It cannot be done in any other way.

The great growth of voluntary health and hospital insurance plans and the advent of catastrophic coverage, the unprecedented accomplishments of the past 25 years, the great increase in longevity, the excellent work of our various councils and committees in the American Medical Association are easily forgotten, but not so unethical practices of any kind. True, some of our critics are unfair, explaining only that which is bad and giving no credit for positive accomplishments. And some, I find, are not even sympathetic to American fundamentals. As citizens and doctors we must not give them a target to shoot at. No group of humans can be perfect, but we can seek perfection in the discharge of our humanitarian duties—and in seeking perfection we shall find good public relations! There is no other answer.

In the past six months I have also learned that our economic problems are not solved, as some physicians seem to believe. As a matter of fact, these problems have increased. The socialistic trend and government intrusion into the business and affairs of the people have shown little evidence of change. The greatest battle for the preservation of democracy is yet to come. I see it in the demands of some labor unions and in the desires of certain professional veterans to continue unabated the ever-increasing government support of more than 20 million veterans. I see it in the drafting of doctors for an ever-growing dependent care program, as well as in proposals from federal sources that the government buy hospital and medical care insurance for members of the armed forces and their families. I recognize it in the long list of diseases presumed to be service-connected. It appears in the statements of elected public officials who believe that it is "good politics" to encourage federal handouts of all kinds and who, by innuendo and by word, magnify the medical needs of our people and pay little heed to the many more important problems affecting American men and women.

If America is to survive as a democracy, in which man is recognized as having been created "in the image and likeness of God," possessed of a soul, and having certain inalienable

rights and privileges, then we, as doctors and leaders, must request that all other groups, including writers, journalists, union leaders, and industrialists adopt a similar code of ethics, or, if they have such a code, make it just as operative as they expect the medical code of ethics to be. Our friends and fellow citizens in other vocations, including public officials, must conduct their affairs with the same dignity and integrity manifested by the great majority of physicians. If we police our own ranks, as we have tried to do for centuries, they should do likewise.

Finally, It would seem to me that, since medicine in America is the best in the world and improving every day, orators, writers, and others might do well to devote more of their attention to far greater problems affecting the health and welfare of the people, such as housing, sanitation, juvenile delinquency, nutrition, un-Americanism in many of our institutions, dishonesty of public officials, gambling, gangsterism, and other cancers on our national economy, including the collectivists and socialists and communists, and those who, having lost sight of God, have forgotten that we are a great nation because of a Constitution written by men with a deep faith in the Supreme Being, faith in opportunity, and in private enterprise.

The councils and committees of the American Medical Association have done and are doing magnificent work in the field of public service. I know of no other organization which spends so much time and money in altruistic purposes. It seems, however, that many doctors and most laymen know little of the unselfish accomplishments of medical organizations. It would seem that newer techniques should be developed to carry to physicians and others the problems which daily confront your officers, Board of Trustees, and councils and committees. I make this statement because I am convinced that the great percentage of our membership, while acquainted with our scientific endeavors, are devoid of knowledge of the hours of work and travel given without remuneration by the elected officials of the American Medical Association family and members of this House of Delegates. I should like to see this information carried into every doctor's home—short, concise, and readable.

For example, I dare say that there are many physicians in St. Louis today who have no knowledge of the work and decisions of our Committee on Legislation. How can they be forceful in discussing these problems? How can they be encouraged to read the Organization Section of THE JOURNAL? Is there a better way of bringing greater understanding of medicoeconomic problems into the doctor's living room? Can a better method be designed to bring medical problems to the busy doctors? I submit these questions to this House of Delegates and to our state executives and county societies in good faith, with the firm conviction that, despite our efforts and hard work, unwarranted criticism comes from many sources due to lack of knowledge on the part of some physicians and laymen of our aims and purposes.

There are many other subjects that I might discuss, but time will not permit. I should like to suggest to this House of Delegates and to our Council on Medical Education and Hospitals that the time has come when we should insist that a reasonable amount of time be devoted by our medical school faculties to the formal teaching of medical ethics and the religious fundamentals which are just as evident in the Oath of Hippocrates and the Principles of Medical Ethics as they are in the Constitution of the United States of America. Here again is a job for the "grass roots," in this case the medical schools. On them must rest the responsibility of graduating men and women of character who will be immune to socialism and communism as well as unethical practices in medicine. It is comparatively simple to train a person to be upright and honest, but it is difficult to convert such a person when he or she has strayed from the path of honor and brought reproach on the world's most honorable profession.

When one becomes President of the American Medical Association, he has received medicine's greatest honor! He likewise has assumed a position which is rapidly becoming a full-time responsibility. Permit me to admit that without the excellent staff provided at the headquarters office I would be unable to carry on. Every council and committee, each and every department head has rushed to my rescue on many occasions! We have as fine and capable a group laboring for us day and night in Chicago and in Washington as has ever been assembled by any major organization. To them one and all, my gratitude and thanks.

To you, my colleagues of this House of Delegates, I wish to restate my earnest pledge to carry your thinking throughout our great country. I hope that six months from now, after having completed the mission to which I have dédicated myself, I can find peace of soul and heart because of few, if any, errors of omission or commission. This goal I shall be able to achieve only with your help and support. Let us all resolve here and now to carry on in our efforts to bring the best medical care to all the people in our native land and to oppose each and every suggestion which directly or indirectly would seem to jeopardize our great democracy.

Report of Reference Committee on Reports of Officers

Dr. George M. Fister, Chairman, submitted the following report, which was adopted:

Your committee received for consideration the address of President Edward J. McCormick. At the Clinical Meeting on Dec. 1, 1953, and in a brilliant and factual manner, President McCormick reviewed the first six months of his stewardship, and indicated the arduous road that our profession must travel with increasing vigilance and unity if our objectives are to be realized and our ambitions brought to fruition. In his New York address in June, 1953, President McCormick recommended nine major activities to the accomplishment of which he has directed his energies. It is gratifying to have him state that progress has been made. Your committee believes that this statement is too modest. Our relations with the public must and shall be improved. President McCormick points the way. Your committee believes, with him, that public relations is a "grass roots" problem, and interprets "grass roots" to mean every physician in his every contact with every patient every day. This is fundamental.

A committee, on state or county level, to hear and evaluate complaints and criticisms is of value in direct ratio with the courage of its personnel. The legal concept that the greatest deterrent to crime is the certainty of punishment should enhance the value of such committees.

We, as a profession, are subjected to much unfair criticism from the public and, regrettably, from some of our colleagues. Of our unethical and critical colleagues we may paraphrase and say, "Never before have so few done so much harm to so many." President McCormick suggests the remedy. He advises that "we seek perfection in the discharge of our humanitarian duties" and that we demand integrity and intellectual honesty in our critics.

If we are to acquaint the public with our real objectives and accomplishments, we must educate ourselves. President McCormick suggests that all physicians read the Organizational Section of THE JOURNAL and that the Principles of Medical Ethics be taught in medical colleges. Your committee congratulates President McCormick on his courageous attitude regarding government intrusion into what should be the private affairs of our people. Attention is called particularly to the arduous duties of the Presidential office, and to its physical, mental, and professional sacrifices.

Your committee suggests that this splendid address be disseminated as widely as possible through all channels of publicity.

Presentation of Drs. Julian P. Price and Carl H. Gellenthien

The Speaker presented to the House of Delegates for recognition Dr. Julian P. Price, Florence, S. C., Trustee, and Dr. Carl H. Gellenthien, Valmora, N. Mex., Vice President, who had been elected to their respective offices at the New York meeting but who, in the rush preceding adjournment, had not been introduced to the House.

V 1
195

Presentation and Address of Dr. Chester S. Keefer

Dr. Edward J. McCormick, President, was granted the privilege of the floor for the introduction of Dr. Chester S. Keefer, Special Assistant to the Secretary of the United States Department of Health, Education, and Welfare. Dr. Keefer addressed the House as follows:

Dr. McCormick, Mr. Speaker, Members of the House, Fellow Members: I wish to thank your president for inviting me to come here this morning and for the opportunity of addressing you. In June, 1953, Mrs. Hobby, the Secretary of the Department of Health, Education, and Welfare, addressed the House of Delegates and outlined the responsibilities of the Department in the areas of health. She defined the responsibilities as those functions which serve the health of the nation without affecting the doctor-patient relationship in medical practice. The Secretary directed attention to the department's activity in public health, in research and rehabilitation. These are matters that this Association has been concerned with for many years, because you have an intelligent grasp of their significance in the conservation of the human resources of the nation. Mrs. Hobby also stated that the common objective of the department and of the medical profession was to promote the best medical care and the highest level of health possible for the people. The means of reaching these goals raise many of the current problems, but I submit that with the leadership of this Association and the other health professions solutions can and will be found that will receive public acceptance. In the past, this Association has taken positive action with respect to advocating measures which are clearly in the public interest and general welfare, so that the people are justified now in looking to you for such leadership in the future.

The medical care of today is quite different from 25 years ago, and I am inclined to believe that you will agree that its present high quality is due to the principles that this Association has insisted on in the past, namely to advance the boundaries of medical knowledge, to elevate the standards of education, and to base the practice of our art on scientific principles and sound experience. It is proper therefore that the Association should continue to support scientific research, to examine the standards of medical education, and to further its development. This is the foundation on which the high quality of medical care rests. It is the function of the Association to utter the voice of medical science to the public concerning the significance and importance of research and medical education in the health problems of our country today.

I need not remind you that this Association has been responsible in large part for elevating the standards of medical education in the United States. This has been accomplished in the past by insisting on high standards, by approving or disapproving the performance of schools, and by informing the public of your ideals and objectives. This has been successful because the standards have been related to quality.

There are at least four agencies that are responsible for high quality of medical care and for the promotion and maintenance of the good health of the people. They are the medical schools, the hospitals and their staffs, the public health departments, the medical and other health professions.

First let me say a few words about the medical schools. The American Medical Association has had a continuing interest in medical education. The standards of such education are under constant examination by the Council on Medical Education and Hospitals, and periodic national surveys have been made and sponsored by your organization with the support of others. The most recent survey by the Committee on Survey of Medical Education has been reported in a book entitled "Medical Schools in the United States at Mid-Century." This study shows what progress has been made in medical education in the United States since 1910, but one also gathers from these reports that there are many problems that need urgent attention because there are danger signals ahead. When a patient is placed on the "danger list" by the physician it is putting the family, the friends, and the public on notice. The outlook is uncertain, and the patient may die. Bold action, soundly conceived, will be necessary if the standards of our medical schools are to be maintained and if they are to continue to meet their mounting responsibilities. Increased financial support from the public is urgently needed to meet the rising deficits. This is a challenge that must be met. The attitude of physicians should be clear in the matter of education, for the strength and credit of the profession, the great interest of the public health, and the welfare of the individual all depend on the quality of training given in our medical schools. The medical schools need the full support of the profession and of the public. The people need to be informed that they have a vital stake in the quality of medical care, and that is determined in large part by the education of our doctors and other members of the health professions. The medical schools of this country are almost equally divided between two types; the tax-supported, and the non-tax-supported. This has proved to be a healthy balance. However, the greatly increased financial burden which weighs equally upon all is jeopardizing particularly the future of the private institutions without large financial resources. The American Medical Education Foundation and the National Fund for Medical Education are making valiant and praiseworthy efforts to meet the increased costs of medical education within the framework of our private enterprise system and without resort to Federal assistance. May their efforts prosper, for this is not a time when this country can afford to cut down on its production of medical manpower.

Aside from the education of the members of the health professions, it is necessary that adequate facilities be available in the community so that doctors may utilize their skills and apply new scientific knowledge in the prevention and treatment of illness. Of great importance are the hospitals of the nation because these facilities and their staffs play an important role in providing essential health services to the committee that they serve. The public should be informed that equal opportunity for medical care is concerned with community facilities as well as adequately trained personnel. When facilities increase and improve and when well-educated physicians are trained, then the quality of medical care improves. This statement does not imply that the facilities need be the same in all areas. They must be adapted to the region and they must be selected in accordance with need. *This is a matter for each local community to decide for itself.*

The third agency that plays an important part in our health team are the health officers and their departments. They serve, educate, and protect the community against the hazards of illness. They assist the practicing physician in carrying out his mission and in safeguarding the public health. Their education, their development, and their opportunities are important to all of us.

The fourth agency that holds the major responsibility for promoting and maintaining the health of the nation is the medical profession. The profession must be the leader, and to reach their full potential requires the cooperation and the coordination of activities of the other health professions, including dentists, nurses, pharmacists, and the many groups of paramedical and technical workers. In short, the health of the nation is promoted by a team, and the medical profession must be the leader of the entire group. For this team to be most effective there must be good personal relations and understanding between the organized professions and the people whom they serve. The so-called doctor-patient relationship which we all prize so highly and which is the basis for the present day medical practice must extend to group relations, that is to say, the relations between the organized health professions and the people must be carried on with the same depth of understanding as the relationship between the individual doctor and his patient. One of the best ways of accomplishing good group relationships is for the profession to understand fully the needs of the people and for the profession to place themselves in the position of the patient.

The total problems of medical care will continue to require constant study. The problems are very broad, and include medical education, medical research, hospitals and their staffs, public health departments, the professions, and the people. The major question before us is how can we continue to produce and promote the finest medical care in the world today. Our needs are for improved medical education; for coordination and extension of facilities and personnel; geo-

graphical extension of services; and bringing the cost within the reach of more people. These needs will be met in our free society by the combined efforts of the laymen, and the members of the health professions working closely together with a sympathetic understanding in their local communities. The voluntary way has been most successful in the past and there are reasons to believe that it will continue in the future. We need experimentation in the field of medical care in order to find the answers to many problems. Experimentation should be carried out by the profession with the full cooperation of the people of the community and the maximum decision should be made at the local community level.

In 1910 the American Medical Association held its 61st annual meeting here in St. Louis. Dr. William H. Welch was President, and he selected for his Presidential Address the title, "The Fields of Usefulness of the American Medical Association." The final two paragraphs of his speech were devoted to the topic of "organized effort." They are as applicable today as they were 43 years ago, so with your permission I am going to conclude by reading them.

"Organized effort is a distinguishing mark of modern civilization. It is as essential for the advancement of science, of education, of social and industrial reform, of philanthropic endeavor, as for the promotion of commerce. With the remarkable progress of medical science, especially during the last three decades, man's power to control disease has been vastly increased, and the sphere of usefulness of the physician has been correspondingly widened, and with advancing knowledge will continue to expand. The skill and knowledge of the physician and sanitarian have acquired a new and ever increasing amelioration and significance in the movements for social amelioration, for improvement of the conditions of labor and of living, for the conservation and most efficient utilization of the productive energy of the world, and for the reclamation of regions now yielding no return to civilization.

"Among the organized forces for advancing the prosperity, the happiness and the well being of the people of this country, the American Medical Association has an important part to play. We are justified in the confidence that, with the united support and loyalty of the profession, the association, broadly representative and standing for the best ideals of medical science and art and for professional and civic righteousness, will contribute a beneficient share to the working out of our national destiny."

Introduction and Address of President of American Dental Association

The Speaker introduced Dr. Leslie M. Fitzgerald, President of the American Dental Association, who addressed the House as follows:

Dr. McCormick, Mr. Speaker, Trustees, Members of the House of Delegates of the American Medical Association: It is a great privilege for me to be here today to represent the officers and trustees of the American Dental Association.

I thought it might be of a little interest to some of you to know a few of the facts of our organization. Many of you know them, possibly some of you do not. The American Dental Association has a membership of approximately 80,000. We take great pride in the fact of such a large percentage of the practicing dentists being members of the American Dental Association. Eight out of every nine practicing dentists in the United States are members of the American Dental Association. Our organization is very similar to yours, operating under a house of delegates and a board of trustees.

The American Medical Association and the American Dental Association represent the two major health professional organizations and therefore share many responsibilities, such as improvement of the health of the public by the prevention and control of disease, advancement of the art and science of medicine, constant vigilance against political encroachment on the health profession services to the public, and improvement of public relations.

At this time, I would like to mention briefly one field in which the two professions have shown spectacularly close cooperation. I am referring to the fluoridation of the public water supplies, one of the greatest advances in the history of preventive dentistry. The story of fluoridation is a stirring tribute to research. The program is now in operation in over 800 communities and one out of every nine persons in the United States is routinely drinking fluoridated water. Local medical and dental societies have taken an active role in encouraging this measure. The cooperation of the medical and dental professions on this measure seems to me to be a graphic example of the health professions living up to their highest responsibility, the prevention and control of disease.

The united efforts of the American Medical Association and the American Dental Association also have done much to defeat unsound and ruinous legislation at both the national and local level. The American Dental Association House of Delegates, at its annual meeting in Cleveland last September, again reaffirmed its opposition to the inclusion of dentists in the O. A. S. I. program. The vote was 6 to 1. The American Dental Association has consistently voiced its opposition to all forms of compulsory health insurance. It is on record as favoring the proposed Jenkins-Keogh Bill.

In conclusion, I wish to state that unity and cooperation of our organizations are basic. If the present high level of health care is to be protected, constant vigilance must be maintained against political encroachment on the health profession services to the public. When politics takes over, the welfare of the individual patient becomes a secondary consideration. The American Dental Association pledges its continued support of sound legislation for the advancement of the art and science of medicine and for the betterment of the health care of our nation. The great prestige of the health professions rests firmly on a solid basis of organized strength. This the American Medical Association and the American Dental Association should preserve.

Introduction and Address of President of Woman's Auxiliary

Mrs. Leo J. Schaefer, President of the Woman's Auxiliary to the American Medical Association, was introduced by the Speaker, and presented the following address:

Mr. Speaker, Dr. McCormick, Dr. Martin, Board of Trustees, and Members of the House of Delegates: I am very pleased to have this opportunity to report to you on the progress of the Auxiliary and to bring greetings from the 64,000 members. Within the 48 state auxiliaries, the District of Columbia, and the territories of Hawaii and Alaska, we have more than 1,130 county auxiliaries. We are fully cognizant of the fact that we are an auxiliary to our parent organization, the American Medical Association, and as such undertake projects approved by our Advisory Committee, which will assist the medical profession in its program for the advancement of medicine and public health.

In reading the papers, the magazines, listening to the radio, and watching TV, we are aware that people do want to know about subjects relating to health. The Auxiliary, through its state and county units, can make an important contribution to the community when it interprets the problems of medical care to the public. Programs for our Auxiliary meetings must be planned to inform our members on problems facing the medical profession and ways in which physicians are solving them. As Auxiliary members we have a two fold service to render, (1) education of ourselves in subjects relative to the medical profession and (2) bringing this message of medicine to our home communities through the organizations in which we hold membership. There was a time not too many years ago when it was not necessary for a physician's wife to be informed concerning health problems that affect the public, but today she must be informed or offer no comments.

Members of the House of Delegates, we need your help. The American Medical Association reports a membership of 140,000. At the close of our June fiscal year we had 64,000 members. Our organization chairman is asking for a 10% increase in membership this year, but with your help we could double our membership. The present membership is carrying the full program for the Auxiliary. The nurse recruitment program, with its scholarships, loan funds, and Future Nurses Clubs in high schools is outstanding. No doubt you have heard of our contribution to the American Medical Education Foundation fund. Last June for the third consecutive year we gave $10,000 from our income. In addition the state auxiliaries contributed $22,630, and in June, 1954, we are positive that

V 1
195

amount will be doubled. We also take a little credit for the increased contributions from our physicians. We contribute annually $100 to the World Medical Association. Our only source of income is from our $1.00 annual dues per member. A membership paralleling that of the American Medical Association would increase our philanthropic projects. We are aware that *Today's Health* is an excellent medium for distributing authentic health information. People eagerly read medical articles in other magazines, so why not make authentic information available to these readers? Our goal this year is 64,000 subscriptions, or one subscription per member, which is double the subscriptions of last year. Since only 15% of the physicians subscribe to *Today's Health*, with your help we can reach our goal.

Other programs of the Auxiliary do not have such tangible records; their value cannot be estimated in dollars or numbers. We aim to be informed on legislation affecting medicine; we assist with the civil defense program; we inform ourselves concerning mental health, rural health, health days, voluntary health insurance, community health councils, the American Medical Association; the World Medical Association; the World Health Organization; and other health projects such as cancer, polio, and heart.

The conference of state presidents, presidents-elect, national chairmen, and officers held in Chicago last week was attended by representatives from all 48 states. We are grateful for the valuable assistance rendered by representatives from several departments of the American Medical Association and for the excellent address by your president, Dr. McCormick. Each member returned home more eager than ever to assist their state and county medical societies in any program assigned to them.

It has been my pleasure to attend 13 state auxiliary conventions, 4 state board meetings, and 5 other national meetings since June and to witness first hand the fine programs being developed. The Woman's Auxiliary to the American Medical Association truly exemplifies the slogan of this year "Together We Progress." May I add, with your continued help "Together We Can Progress" more rapidly. I thank you for this opportunity to be with you today.

153
53

Introduction of Student A. M. A. Delegates

The Speaker introduced Mr. John H. Caskey, Baylor University College of Medicine, and Mr. David J. LaFond, Marquette University School of Medicine, delegates from the Student American Medical Association, who presented greetings from their organization.

Presentation and Remarks of Rev. Alphonse M. Schwitalla, S.J.

Rev. Alphonse M. Schwitalla, S.J., of St. Louis, was presented by the Speaker, and addressed the House as follows:

Being a Jesuit priest precludes any possibility of my ever attending a conclave of the Cardinals for the election of a Pope, so my next ambition has been, before I die and make a report to the "Big Boss," at least to have once appeared before the House of Delegates of the American Medical Association.

The American Medical Association is composed of a group of sound thinkers, and in the work that I have done I have felt that whenever I have made a false step, it was always because I had done something that was contrary to what the American Medical Association has taught. Fortunately, I have had friends like Ed McCormick and Herman Weiskotten and Dr. Cutter and a few other people who have acted as intermediaries between you and me.

Just yesterday I was reading up on old Grecian medicine in connection with something else, and I was amazed to find that way before the Homeric days the Greek doctor was called a *Demiourgos*, that is, a worker for the people, and through all these centuries, gentlemen, you have been *Demiourgoi*, working for the people. It was only in the second stage of medicine that you became the *Iatrouantheis*, the physician-prophet, and only after the Trojan War did the doctor get the title by which he goes today in Greece, and that is the *Iatros*, the physician. Gentlemen, there is a significance in that stratification of responsibilities. From the earliest days, the foundation was laid for you to be helpers of the people. Gentlemen, I have a great, great admiration and love for the American Medical Association, and it has been one of the great honors of my life that the medal that I am wearing this morning has been granted to me through your generosity. It means so much to me, and thank God that I have had the opportunity of appearing at least once before this great House of Delegates. Thank you very much.

Report of the Secretary

Dr. George F. Lull, Secretary, presented his report (see THE JOURNAL, Nov. 7, 1953, pp. 926-928), which was referred to the Reference Committee on Reports of Board of Trustees and Secretary, with the exception of the item relating to a Resolution on Payment of Back Dues introduced at the New York meeting, which was referred to the Reference Committee on Amendments to the Constitution and Bylaws.

Report of Reference Committee on Reports of Board of Trustees and Secretary

Dr. John J. Masterson, Chairman, presented the following report, which was adopted:

Membership: It was very gratifying in reading the report of the Secretary, that the paid membership as of Aug. 31, 1953, was 117,063, an increase of 7,323 members over the corresponding period in 1952. This increase in membership is concrete evidence of the confidence of the profession in the policies of the Association and our endeavors in promoting and improving the health and well being of the American public. We are pleased to learn that plans are being made to expand the use of the I.B.M. system during 1954 in order that the membership cards may be sent at the time the dues are recorded. The installation of this system will avoid many complaints regarding delay in receiving membership cards and also in receipt of THE JOURNAL or one of the specialty journals by new members.

The Secretary makes reference to another problem, which is the variety of membership classifications in constituent associations, resulting in confusion as to the type of membership a physician may hold in the American Medical Association. The problem arises out of provisions in the constitutions and bylaws of the constituent associations, and for that reason cannot be easily or quickly solved. Another source of misunderstanding is the use of various terms to designate categories of membership. Your committee is pleased to note that the Secretary has undertaken a new survey of the constitutions and bylaws of constituent associations with respect to provision for exemption from payment of American Medical Association dues, and that further recommendations can be made at completion of the study.

Subscription and Circulation: The number of subscribers to THE JOURNAL was about the same as in 1952, although many members substituted one of the special publications in place of THE JOURNAL. All of the nine publications showed an increase in circulation.

Field Activity: Many invitations are received by the Secretary and Assistant Secretary to address meetings of state and county medical societies and other organizations which maintain cordial relations with the American Medical Association. These invitations are accepted whenever possible, notwithstanding that such attendance places an additional burden of work on their return to headquarters.

Directives of the House of Delegates: The Secretary has made disposition of resolutions adopted by the House of Delegates at the New York meeting. His report on the Resolution on Payment of Back Dues has been referred to the Reference Committee on Amendments to the Constitution and Bylaws.

Collier's Article: An article appeared in *Collier's* magazine for Oct. 30, 1953, entitled "Why Some Doctors Should Be in Jail." The Secretary wishes the record to show clearly that he never saw the article, the title, the illustrations, or the cover page before publication. Had it been submitted to him, he would have protested strongly.

In conclusion, your reference committee believes that the House of Delegates would be remiss at this time if it did not

express its gratitude, appreciation, and thanks to our Secretary and Assistant Secretary and all the headquarters personnel in the office and mechanical departments for their continued loyal and faithful service in administration of the affairs of the Association.

Report of Reference Committee on Amendments to the Constitution and Bylaws

Dr. William L. Benedict, Chairman, presented the following report, which was adopted:

Your committee has considered that portion of the report of the Secretary on payment of back dues. This refers to a resolution presented to the House of Delegates in June, 1953, by Dr. George A. Earl of Minnesota concerning the payment of membership dues. This committee presents a substitute resolution as follows:

Resolved, That any active member of the American Medical Association who failed to pay dues for the year 1950, and who was suspended for such delinquency, may be reinstated during the first six months of 1954 by the payment of 1954 dues only. Should such an individual fail to pay his 1954 dues by July 1, 1954, he shall continue to be considered delinquent.

Your committee further recommends that the Bylaws of the American Medical Association be so amended as to implement this provision.

Report of Board of Trustees

Dr. Dwight H. Murray, Chairman, presented the report of the Board of Trustees (see THE JOURNAL, Oct. 31, 1953, pages 829-854, and Nov. 7, 1953, pages 928-940), which was referred to the Reference Committee on Reports of Board of Trustees and Secretary with the following exceptions:

To the Reference Committee on Legislation and Public Relations, Report of Committee on Legislation and Report of Assistant to General Manager, Department of Public Relations.

To the Reference Committee on Industrial Health, Report of Council on Industrial Health.

To the Reference Committee on Medical Military Affairs, Report of Council on National Emergency Medical Service.

To the Reference Committee on Insurance and Medical Service, Report of Council on Rural Health.

To the Reference Committee on Hygiene and Public Health, Report of Committee on Mental Health and Report of Bureau of Health Education.

To the Reference Committee on Sections and Section Work, Report of Bureau of Exhibits.

Report of Reference Committee on Reports of Board of Trustees and Secretary

Dr. John J. Masterson, Chairman, presented the following report, which was adopted:

Report on Matters Referred by House of Delegates: With respect to that section of the report which has to do with resolutions referred to the Board of Trustees, your committee finds that in each and every instance they have been studied by the Board of Trustees and referred to the proper Committee or Council or person for action, or have been implemented by the Board of Trustees in accordance with the recommendations of the House of Delegates.

The Journal, Specialty Journals, Library, Today's Health: THE JOURNAL is ever-enlarging and continuously expanding in the diversification of reading matter. Valuable and interesting new departments are constantly being added. THE JOURNAL continues to increase its effectiveness internationally by ever-increasing international circulation and the inclusion for American readers of increasing numbers of articles of scientific and general interest. Its publication figure has now reached 167,000 copies per week.

Special attention is being given by the Editor to improve the specialty journals. The program as laid out will, it is believed, markedly improve the editing policies. Also, greater efficiency in production will no doubt be realized by the efforts being made in the field of training personnel. Financial improvement is anticipated by improvement in sales policies. The specialty journals are constantly increasing in circulation, which, in the opinion of your reference committee, is evidence of their ever-increasing improvement.

The Library is mentioned in this report only to call your attention to its continuous growth; 4,065 volumes are now in the Library. Extensive, valuable files and indexes of THE JOURNAL, authors, specific subjects, book reviews, etc., have been arranged for efficiency and accessibility. The Library is in a position to render valuable service to the members of the profession.

The magazine *Today's Health* is, in the opinion of your committee, an exceedingly important and efficacious medium in the public relations and public education in health functions of the American Medical Association. Despite this importance, your committee believes that it cannot fulfill its purpose at the present time because of insufficient circulation. The total subscription to *Today's Health* at present is 260,000. Of this total, it is disappointing to learn that only 26,000 members of the profession subscribe to this magazine. An annual deficit results from this situation to the extent of $150,000, and it is a serious question whether this valuable medium can be continued. It is urgently requested that the members of the profession seriously consider supporting *Today's Health* by subscribing to it. Your committee is informed that if the number of physician subscriptions were raised to 100,000, the present deficit could be eliminated. Your committee also urgently recommends that efforts be made by component medical societies to increase subscriptions to *Today's Health*.

Report of Washington Office: In the opinion of your committee, this report requires no critical analysis. The service rendered by the Washington Office has been most valuable to the profession. To read its regular reports is to determine the many services it renders. The accomplishments of this office since its beginning must be known to each member of the House of Delegates. In the opinion of your committee, the initiation of this service in Washington has been one of the best investments of the profession. We are grateful to its Director, Dr. Frank E. Wilson, and declare our wholehearted approval of his efforts.

The effectiveness of the Washington office is dependent on hometown utilization of the information supplied by the Washington Office. Your committee recommends that the members of the House of Delegates make every effort to present the medical viewpoint on all legislative information supplied by the Washington Office to their representative members of the Congress of the United States.

Report of Committee on Medicolegal Problems: In the field of medicolegal problems, which has always been a too little understood facet of practice by our profession, much has been done to clarify and bring to the profession its importance. Particularly is this true in the prevention of malpractice actions. Considerable information has been made available to the profession regarding its rights, duties, and obligations. Dissemination of scientific knowledge on the subjects of preventable dangers of blood transfusions and the accurate diagnosis of acute alcoholism has been emphasized. In the field of forensic pathology, the subcommittee has cooperated with various legislative bodies in an effort to have established uniform state laws that would create a model medical examiner law. The importance of this requires no additional comment by your reference committee.

The interrelationship of the Committee on Medicolegal Problems and the Bureau of Legal Medicine and Legislation is a happy situation. This cooperation, it is hoped, will continue.

Report of Bureau of Legal Medicine and Legislation: The Bureau of Legal Medicine and Legislation, because of its long experience and accumulation of legal information, is in a position to, and does, render to the profession valuable services. The Bureau's cooperation with the Federation of State Medical Boards of the United States in an effort to improve and more nearly approach uniformity of the various medical practice acts is to be commended.

It is interesting to note in the report of the Bureau that in the state of Ohio the decision of the attorney general of Ohio leaves no doubt as to when a hospital is illegally practicing medicine. This opinion is parallel to the position taken by the American Medical Association and many of its component societies.

V 1
195

Continued study is being made by the Bureau, in conjunction with the Council on Medical Service, into the subject of medical liability insurance rates charged by the insurance carrier of malpractice insurance. This study, although not completed, is evidently being continued with progress. However, because of the ever-increasing premiums charged for malpractice insurance protection and, more important, the increasing reluctance of insurance carriers to continue the availability of this protection, your committee recommends that the Board of Trustees make every effort to improve this deteriorating situation as soon as possible.

Report of Council on Pharmacy and Chemistry: The evaluation of new drugs and the drug acceptance program of this council have been a most practical and useful project provided by the American Medical Association for the individual practitioner of medicine. Likewise, its publications and reports are of great clinical value. Particularly to be commended is the report of the Committee on Research, reporting the cooperative investigations with various pharmaceutical manufacturers. The grants-in-aid through the Committee on Research is a most remarkable example of the altruistic aims of modern medicine as expressed through its official organization.

Report of Committee on Cosmetics: The report of the Committee on Cosmetics demonstrates again the opportunity for the medical profession, through its agencies, to develop close cooperation with better business bureaus and other organizations and agencies for the public good.

Report of American Medical Association Laboratories: The Chemical Section of the Laboratories establishes standards for remedial products, makes available to the profession information relative to New and Nonofficial Remedies, and cooperates in an advisory capacity with other agencies of the Association. The special problem relative to the study of cigarettes has aroused public interest, and further improvement of analytical methods and techniques is to be encouraged.

The Microbiologic Section is a department that serves to study bacteriologic problems relative to medicinal remedies and also offers a very practical future for cooperation with certain food industries.

Report of Council on Physical Medicine and Rehabilitation: This council has continued its investigations of appliances and methods for aiding those handicapped by loss of important body functions and has actively disseminated information to the medical profession and to the public on the value and use of such aids. It has continued its interest in the education of physical and occupational therapists.

Report of Council on Foods and Nutrition: This council has concerned itself with the evaluation of certain foods prepared for use in low sodium and weight-reducing diets, the proper investigation of which will lead to more accurate and dependable labeling and a wider knowledge of the variety and types of foods available for such therapeutic use. The recognition of the valuable work of Dr. William H. Sebrell by the Council in recommending him for the Joseph Goldberger Award is a tribute to the work done in the field of clinical nutrition. The pioneering work of the Council on evaluating the use of vitamin and nutrient enriched foods serves as a further reminder of the outstanding and enviable position of this Council in its service to the public. Death and illness have necessitated changes on this council and further illustrate the toll of hard work and devoted service that has so often characterized membership on councils of the American Medical Association.

Report of Bureau of Investigation: The never-ending exposure of quacks, cultists, patent medicines, and similar fads, agents, and appliances has been carried on in increasing degree, and probably more effectively owing to the use of radio, television, and other means of public information dissemination.

Report of Bureau of Medical Economic Research: This has proved to be one of the most valuable departments of the American Medical Association. It has done more to give the public and the profession accurate and honest factual data on medical economic problems and by so doing has successfully refuted much of the socialistic philosophy which has been rampant in the United States in recent years. By so doing it has accomplished a great deal toward the preservation of freedom in our country. Because of the accuracy of its findings and conclusions, it has gained the confidence of many outside the medical profession. Its director has proved himself to be a competent, honest economist, and for his leadership and the work of this bureau we are sincerely appreciative and most grateful.

Report of Bureau of Industrial and Personnel Relations: This bureau has established a pattern for the proper regulation of its employee relationships to the Association. It has done a most creditable job in fostering the type of program for its employees that leads to harmonious, cooperative effort so important to an organization dependent on a large number of persons for efficient operation.

The report of the Board of Trustees, covering 135 pages in the Handbook of the House of Delegates, is an indication of the great amount of work required of the Board. A perusal of the report is eloquent testimony to the loyal and selfless devotion of the members of the Board of Trustees to the duties of their office. They spend many days and long hours in working on the affairs of the Association. Your committee does not think that any other organization has a more faithful Board of Trustees. We owe them our deep gratitude, sincere thanks, and appreciation.

In conclusion, may we convey to the other members of our committee our sincere thanks for their generous, gracious cooperation and assistance in the preparation of this report.

Report of Reference Committee on Legislation and Public Relations

Dr. Bruce Underwood, Chairman, submitted the following report, which was adopted:

REPORT OF COMMITTEE ON LEGISLATION

Resolution on Social Security and Report of Committee on Legislation on Jenkins-Keogh Bills (H. R. 10 and H. R. 11): Your committee carefully considered resolution No. 10 on the subject of social security, introduced by Dr. Willard A. Wright, North Dakota, and the Report of the Committee on Legislation of the Board of Trustees on the Jenkins-Keogh bills. The purpose of these bills is to eliminate the discrimination and inequities which exist under present tax laws by extending the tax deferment privilege to the country's 10 million self-employed and also to millions of employees who are not covered by pension plans. The purpose of the resolution is to reaffirm our support of the voluntary pension program provided in the Jenkins-Keogh bills and to reaffirm our strong opposition to the extension of compulsory coverage of physicians and other self-employed persons under Title II of the Social Security Act. Your committee recommends the adoption of the resolution.

Legislation to Amend the Constitution of the United States Relative to the Making of Treaties and Executive Agreements (S. J. Res. 1): Your committee endorses the efforts that have been made to secure a favorable action concerning this legislation. We are glad to note that it has been reported favorably by the Senate Judiciary Committee and that it is now awaiting action by the Senate. Your committee urges continued efforts to secure favorable action on the resolution.

Legislation Concerning Transfer of Functions, Responsibilities, and Duties of Department of the Interior and Bureau of Indian Affairs Relating to Health and Hospitalization of Indians to United States Public Health Service (H. R. 307 and H. R. 1057): Your committee endorses the action taken to date with respect to this legislation and urges continued efforts to secure favorable action.

Legislation to Authorize United States Public Health Service to Admit to Its Hospitals Persons Committed by State Courts Who Are Beneficaries of the Service or Narcotic Addicts (H. R. 3204): Your committee endorses the action of the Committee on Legislation and the Board of Trustees in recommending the enactment of this legislation.

Legislation Concerning Deduction of Medical and Dental Expenses for Income Tax Purposes (H. R. 3375): Your committee endorses the action of the Committee on Legislation and the Board of Trustees in actively approving the principle

involved in this legislation. It urges that efforts be continued to secure a greater measure of relief for those individuals who have suffered from the financial burden resulting from the expense of a serious long-term illness by reducing or removing the limitation on the deduction of medical and dental expenses for income tax purposes which are imposed by existing law.

Legislation Concerning the "Doctor-Draft" Law (H. R. 4495): The "Doctor-Draft" law was extended for two years and will now expire on June 30, 1955. The Committee on Legislation and the Board of Trustees recommended that the "Doctor-Draft" law be extended for only one year, but this recommendation was not followed, and on June 29, 1953, the legislation became Public Law 84 (83rd Congress). Your committee endorses the vigorous actions taken by the Committee on Legislation and the Board of Trustees to date. Your committee feels strongly, however, that there should be no further extension of the "Doctor-Draft" law. It feels that the legislation is discriminatory and urges the Committee on Legislation and the Board of Trustees to oppose actively any further extension of the "Doctor-Draft" law.

Legislation Concerning Reorganization of Department of Defense (Reorganization Plan No. 6): Your committee considered this legislation and noted that it became effective on June 30, 1953. It noted that the position of Assistant Secretary of Defense (Health and Medical) had been filled by a Doctor of Medicine, Dr. Melvin A. Casberg, even though the legislation did not specifically require that a Doctor of Medicine be appointed. Your committee hopes that in the future the position will continue to be filled by a Doctor of Medicine.

Regional Legislative Conferences: Your committee feels that the regional legislative conferences were of value and that they should be continued. It feels it is important to have direct personal contact with members of state and local medical societies in order to know their opinions in regard to federal legislation.

Report of Committee on Legislation in General: Your committee noted that during the year reported, the Committee on Legislation held six meetings, analyzed 259 legislative proposals and recommended policy positions on 210 of these measures to the Board of Trustees. We commend the Committee on Legislation for its fine work. While most of its report was reported satisfactorily, your committee wishes to recommend that in the future all items include a statement concerning (1) the present status of the legislation and (2) the nature of testimony given which would clearly indicate the position of the Association. We feel this information should be given for all items of legislation, so that the entire membership of the House of Delegates may be fully informed.

Report of Assistant to General Manager—Department of Public Relations

Public Relations Program for 1953: Your committee endorses the program which has been adopted and the objectives listed. It endorses efforts to reach medical students, interns, and residents and feels these efforts should be continued and expanded. It commends the Department of Public Relations for the fine work it is doing with a staff of 20 employees.

Advisory Committee: Your committee noted that the Advisory Committee to the Director of the Department of Public Relations is concerned only with operational procedures and that all policy decisions are made by the House of Delegates and by the Board of Trustees. It noted that the Assistant Secretary of the Association, and frequently a member of the Board of Trustees sits in on the meeting of the Advisory Committee, and that all recommendations of the committee that involve policy are referred to the Secretary and General Manager, who transmits them to the Board of Trustees for action.

Press Relations: Your committee spent much time in considering this subject and feels it is of the utmost importance to cooperate with the members of the press, radio, and television. We noted that cooperation paid great benefits in mutual trust and understanding and that many difficulties were solved in this manner. We noted that there were 185 reporters and writers at the annual meeting in New York in 1953 as compared to 110 at the 1952 annual meeting in Chicago. We noted the complimentary remarks which have been made concerning the press relations of the American Medical Association. Your committee urges continued cooperation with the press at national, state, and local levels in order to secure a greater mutual trust and understanding of the many problems involved.

Public Relations Conferences: Your committee endorses the holding of public relations conferences and recommends their continuance. It urges, however, a greater participation of doctors of medicine in these conferences.

Daily Bulletin: Your committee noted that 8,000 copies of the Daily Bulletin were distributed at the annual meeting in New York in 1953 and that 3,000 copies will be distributed at the St. Louis Clinical Meeting this year. It notes the improvements which have been made in the bulletin and the increased information given concerning the work of the House of Delegates. Your committee commends these efforts, and expresses appreciation for them, and recommends the continuance of the Daily Bulletin.

Radio and Television Shows: Your committee endorses the fine work that is being done with the promotion of radio and television shows and believes this work is of great value and should be continued and expanded.

Literature: Your committee discussed this subject at length and feels that much good work is being done in the preparation, promotion, and distribution of literature. It notes, however, that the Department of Public Relations does not have any adequate method of determining the value and effectiveness of its work. Your committee believes it is of value and is effective, but recommends that the Board of Trustees establish some procedure to measure its effectiveness. It is suggested that the field service might be used to some extent in this connection.

Other Services: Your committee feels that the P. R. Doctor, the press service which was established for the President, the Presidential Inaugural Ceremony in 1953, the field service, and the guided tours of the Chicago headquarter's office are worthy of special praise and commendation. Your committee commends the Public Relations Department for its long-range program in telling the positive side of American medicine's program with its myriad services and activities.

Report of Reference Committee on Industrial Health

Dr. Frank A. MacDonald, Chairman, submitted the following report, which was adopted:

Your Reference Committee on Industrial Health has carefully studied the report of the Council on Industrial Health and was impressed with the extensive scope of the activities of this council. It was also impressed with the large number of pilot studies being undertaken by this council in the fields of disease and accident prevention, and in health education. Your committee agrees with the scope and objectives of this council and urges that it continue with its studies in industrial and community health councils, in health and welfare plans, and in the professional aspects of sickness absenteeism and workmen's compensation.

Report of Reference Committee on Medical Military Affairs

Dr. William A. Hyland, Chairman, presented the following report, which was adopted:

With regard to the report of the Council on National Emergency Medical Service in the report of the Board of Trustees, your committee feels like many of the delegates who appeared before it complimenting most highly the thought, detail, and mode of expression of the subjects. As a committee we also commend the Board and the Council for this excellent treatise.

Report of Reference Committee on Insurance and Medical Service

Dr. John M. Porter, Chairman, submitted the following report, which was adopted:

The report of the Council on Rural Health speaks for itself and should be read by all of us who practice outside

the metropolitan or industrial centers. If, because of isolation and sometimes apparently radical thinking, the farmer seems to require more than his share of attention or even subsidization, certainly we must agree that no better friend of medicine or more fundamentally necessary individual exists. In the opinion of your reference committee, the work of the Council on Rural Health with its emphasis on education and its admirable record of cooperation with farm groups should be continued and its efforts commended.

Report of Reference Committee on Hygiene and Public Health

Dr. Thurman B. Givan, Chairman, presented the following report, which was adopted:

Report of the Committee on Mental Health: The reference committee commends the Committee on Mental Health (because it is a comparatively new committee, having its first meeting in March, 1952) for the elaborate program it has set out to accomplish. If it can accomplish the raising of the standards of care and treatment of patients in mental institutions, it will have done yeoman work. Your committee recommends that the appointment of a new subcommittee dealing with alcoholism, when a proper survey has been completed, should be effected as soon as possible. Your committee recommends approval of the report as published.

Report of Bureau of Health Education: Your committee has reviewed the report of the Bureau of Health Education and has discussed the subject matter very extensively with Dr. W. W. Bauer. We are tremendously impressed with the vast scope of the work of health education and recommend its continuation and expansion to meet this great need of the American public under Dr. Bauer's direct supervision. We especially commend the cooperation between the American Medical Association and other health organizations, including Secretary Oveta Culp Hobby's Department of Health, Education and Public Welfare, and also the National Committee for Traffic Safety, National Citizens Committee for Educational Television, National Committee on Boys and Girls Club Work, and many other assignments.

Report of Reference Committee on Sections and Section Work

Dr. Jesse D. Hamer, Chairman, submitted the following report, which was adopted:

A review of the report of the Bureau of Exhibits indicates the vast scope of work carried out by this bureau. Not only did it provide many physical exhibits of interest to the general practitioner at the Clinical Meeting in Denver last December, and 260 exhibits at the Annual Meeting in New York last June, with material of high quality and great teaching value to members of the 20 sections of the Scientific Assembly, but also, with the Committee on Medical Motion Pictures, it arranged for the presentation of many films, which were shown to large groups in all instances. Your committee was pleased to note that there are now 50 subjects covered by prepared exhibits, which depict the activities, aims, and purposes of the various councils and bureaus of the Association. These fall into two general groups: (1) medical exhibits for medical societies and other scientific groups and (2) health exhibits for fairs, expositions, and other public gatherings. These exhibits have increased by 12 during the past year.

It is apparent in the report of this bureau that increasing interest continues in the field of motion pictures so that the film library, the film reviews, and films for television assembled by the Committee on Medical Motion Pictures have shown a substantial increase in numbers and more widespread usefulness. Your committee would call to the attention of the House that the secretary of the Committee on Medical Motion Pictures visited Mexico and the First World Conference on Medical Education in London during the past year, and addressed a number of scientific assemblies on the subject "The Effectiveness and Use of Motion Pictures in Medical Teaching."

Your committee wishes to commend the members of the Bureau of Exhibits and of the Committee on Medical Motion Pictures for their excellent work and accomplishments during the past year, and to recommend to the House that the combined report be accepted.

Supplementary Reports of Board of Trustees

Dr. Dwight H. Murray, Chairman, presented the following supplementary reports of the Board of Trustees.

The Speaker referred items A, B, C, K, and N to the Reference Committee on Reports of Board of Trustees and Secretary; items D and G to the Reference Committee on Hygiene and Public Health; items E, F, H, I, and J to the Reference Committee on Medical Military Affairs; and items L and M to the Reference Committee on Medical Education and Hospitals.

A. 1956 Annual Meeting

In accordance with the authority granted by the House of Delegates at its meeting in June, 1953, the Board of Trustees investigated the accommodations in the several cities from which invitations emanated and has selected Chicago, during the week of June 11 to 15, as the place for the 1956 Annual Meeting of the Association.

It is becoming increasingly difficult to select a place for the Annual Meeting which meets the requirements of the Association and at the same time offers a date most appropriate for the needs of the profession. It is recommended, therefore, that the place of the Annual Meeting be selected five years in advance, rather than three, as it is at the present time.

B. Medical Progress Day

At the June, 1953, meeting of the House of Delegates a resolution was introduced by Dr. R. J. Azzari of New York, recommending that a Medical Progress Day be proclaimed. Following receipt of a report from the Department of Public Relations and its Advisory Committee, the Board of Trustees recommends that no action be taken on the resolution. It is the feeling of the Board that the institution of a Medical Progress Day on a nationwide basis cannot be accomplished at this time. It is suggested that if the constituent state and component county societies wish to promote such a day locally they do so whenever possible.

C. Resolution on Crippled Children's Programs

The resolution on Crippled Children's Programs introduced into the House of Delegates in June, 1953, by Dr. Cleon A. Nafe of Indiana, was referred to the Washington Office of the Association. The resolution was brought to the attention of the Secretary of the Department of Health, Education, and Welfare with the request that the section of the regulations cited in the resolution be eliminated. The reply received indicated that the request of the Association would be given careful consideration in the department's exploration of the questions raised by the resolution.

K. World Medical Association

The World Medical Association held its Seventh General Assembly in The Hague, Holland, Sept. 1 to 6, 1953. The delegates from the American Medical Association were Drs. Gunnar Gundersen and Edwin S. Hamilton. The alternate delegates were Drs. F. J. L. Blasingame and Dwight H. Murray. There were also 71 members of the United States committee in attendance as observers besides the American doctors who are officials of the organization. The assembly was the best attended of any. One of the important decisions was to endeavor to coordinate and take the leadership in a world-wide movement to improve the standards of industrial and occupational medicine.

Dr. Austin Smith was named by the council to fill the vacancy in the council caused by the death of Dr. Elmer L. Henderson. This was later confirmed by the assembly. Dr. Gunnar Gundersen was elected to the council to replace Dr. R. L. Sensenich. Dr. Louis H. Bauer remains as secretary general. Considerable discussion took place about the bulletin, and the assembly directed the council to appoint an advisory editorial board composed of three members plus an executive editor, also to be appointed by the council, and the secretary general as business manager. The council appointed the following advisory board: Dr. Paul Cibrie, secretary of the French Medical Association; Dr. Hugh Clegg, editor, *British Medical*

Journal: Dr. Lorenzo García-Tornel, secretary of the Spanish Medical Association, Dr. Austin Smith, editor of THE JOURNAL of the American Medical Association, was designated as executive editor, replacing the former editor. It is contemplated that there will be considerable change in format and the publication will be increased in frequency.

Prior to the General Assembly the First World Conference on Medical Education was held in London. This was sponsored by the World Medical Association. It was attended by 617 registered participants from 62 countries and representing 127 universities and medical schools. Besides obtaining the viewpoints of medical education, medical associations, and government bodies, it endeavored to obtain the viewpoint of the practicing physician on medical education. There was a large delegation from the United States attending the Conference. Dr. Victor Johnson was one of the vice presidents of the conference; Drs. Herman G. Weiskotten and Donald Anderson of the Council on Medical Education and Hospitals, and Mr. Ralph Creer of the headquarters office presented papers, as did several other American doctors.

An attempt is being made by various groups to draft a code of international medical law. None of these groups has any competence in the matter. The World Health Organization was asked by the Belgian government to take action in the matter. The health assembly instructed its director general to undertake a study with the assistance of appropriate organizations and persons and to report back. W. H. O. invited the W. M. A. to take part in this study and stated that W. H. O.'s part seemed to be one of coordination. The stand of the World Medical Association is that any code of international medical law governing the actions of doctors in peace or war must necessarily be based on medical ethics; further, that the medical profession is the only one competent to draw up such a code of ethics; that jurists and governments and governmental agencies should have no part in such a procedure except, perhaps, to give the code legal status after adoption. The World Medical Association has already adopted an International Code of Medical Ethics which has received the approval of this House of Delegates. It is now drafting an additional chapter on the Duties of the Doctor to Society. The World Medical Association has given notice to all concerned that the medical profession will never accept a code of ethics which has been drafted by jurists or governmental agencies.

The Board of Trustees has continued its support of the World Medical Association, as it feels it to be a very necessary organization in that it is the only organization on an international level which can speak for the practicing profession. All other international organizations that deal with socio-economic or educational problems are governmental. The World Medical Association needs financial support. While the dues of member associations are being doubled and supporting committees are developing in other countries, nevertheless for some time to come the majority of the financial support must come from the United States. The United States Committee, Inc., has tripled its membership since a year ago, but it must triple its present membership in order to be self-sustaining in the activities it has agreed to sponsor. The Board of Trustees hopes that the members of the American Medical Association will lend their support to the World Medical Association by joining the United States Committee.

N. APPRECIATION

It is my privilege now to extend my thanks and appreciation to the members of the Board of Trustees for their very intelligent work and for the contributions they are making to the progress of medicine. The long hours and many days they spend in working on the affairs of the Association are done willingly and graciously without a murmur of complaint. The President and President-Elect, by their numerous trips across country to visit the state and county associations, are deserving of great praise and commendation. It seems that more and more these two offices have become full-time jobs for these men. Also may I express appreciation to the headquarters staff who are capable, thoughtful, and diligent in their services and who stand ready at all times to assist the members of the profession.

Report of Reference Committee on Reports of Board of Trustees and Secretary

Dr. John J. Masterson, Chairman, presented the following report, which was adopted:

1956 Annual Meeting: Your reference committee approves the selection of Chicago for the 1956 Annual Meeting, during the week of June 11 to 15. It also approves the recommendation of the Board of Trustees that the place of the Annual Meeting be selected five years in advance, rather than three, as it is at the present time.

Medical Progress Day: Your reference committee concurs in the recommendation that no action be taken on this resolution, as it is the feeling of the Board of Trustees that the institution of a Medical Progress Day on a nationwide basis cannot be accomplished at this time. The Board suggests, however, that, if the constituent state and county societies wish to promote such a day locally, they do so whenever possible.

Resolution on Crippled Children's Programs: The resolution on this subject was introduced at the June, 1953, meeting of the House of Delegates. It was brought to the attention of the Secretary of the Department of Health, Education, and Welfare. The reply received indicated that the request of the Association would be given careful consideration in the department's exploration of the question raised by the resolution. This report is for your information only, and carries no recommendation.

World Medical Association: The first page of this supplementary report is mostly informative of the Seventh General Assembly of the World Medical Association in The Hague, Holland, Sept. 1 to 6, 1953. The delegates from the American Medical Association were Drs. Gunnar Gundersen and Edwin S. Hamilton. The assembly was the best attended meeting of the World Medical Association.

Prior to this meeting, the First World Conference on Medical Education was held in London. The conference was sponsored by the World Medical Association and was well attended. A large delegation from the United States was present.

An attempt is being made by various groups to draft a code of international medical law. None of these groups has any competence in the matter. The World Health Organization was asked by the Belgian government to take action in the matter. The Health Assembly instructed its Director General to undertake a study with the assistance of appropriate organizations and persons and to report back. W.H.O. invited the W.M.A. to take part in this study and stated that W.H.O.'s part seemed to be one of coordination.

The stand of the World Medical Association is that any code of international medical law governing the actions of doctors in peace or war must necessarily be based on medical ethics; further, that the medical profession is the only one competent to draw up such a code of ethics; that jurists and governments and governmental agencies should have no part in such a procedure except, perhaps, to give the code legal status after adoption.

The World Medical Association has already adopted an International Code of Medical Ethics which has received the approval of this House of Delegates. It is now drafting an additional chapter on the Duties of the Doctor to Society. The World Medical Association has given notice to all concerned that the medical profession will never accept a code of ethics which has been drafted by jurists or governmental agencies.

The Board of Trustees has continued its support of the World Medical Association. It is the only organization on an international level which can speak for the practicing physician, and it is hoped that the members of our Association will lend their support to the World Medical Association by joining the U. S. Committee.

Appreciation: Your committee fully concurs with Dr. Dwight H. Murray, Chairman of the Board of Trustees, in expressing his appreciation to the other members of the Board of Trustees, the President and President-Elect, and members of the headquarters staff for their valuable contribution to the Association. Dr. Murray's modest effacement of his own contribution is a merited example of fine leadership.

D. RESOLUTION ON AMENDMENT OF FEDERAL NARCOTIC ACT TO PROVIDE FOR DISPENSING OF CODEINE MIXTURES AND COMPOUNDS ON ORAL PRESCRIPTIONS

Acting on the recommendation of the Reference Committee on Hygiene and Public Health, adopted by the House of Delegates in June, 1953, the Board of Trustees referred to the Council on Pharmacy and Chemistry the resolution introduced by Dr. Raymond M. McKeown of Oregon.

V 1
195

Communications were sent to the Bureau of Narcotics and several organizations interested in this field asking for an expression of opinion as to the advisability of a change in the Federal Narcotic Law at this time to provide for the dispensing of codeine mixtures and compounds on oral prescriptions. In the reply received from the Bureau of Narcotics it was stated, and this was concurred in by the other groups, that the bureau "would favor an amendment to permit the filling of oral prescriptions for compounds of certain narcotic drugs that, as compounds, presented comparatively little or no potential for creating or gratifying drug addiction" and would apparently support "an amendment to authorize this Bureau (after considering any views on the subject expressed by the Surgeon General, U. S. Public Health Service; the Commissioner, U. S. Food and Drug Administration; State Narcotic Control Officers; and the respective secretaries of a national association representing (a) narcotic drug manufacturers, (b) physicians, and (c) pharmacists) to establish by regulation a list of the drugs and compounds found to possess relatively little or no addiction liability. The oral prescription exception is intended to be applicable to substances on this list." The bureau is in the process of preparing such a text embodying the above-stated principle. It was further stated that the extension of the oral prescription classification to mixtures and compounds of the potentially dangerous opium derivatives will inevitably be subverted by drug peddlers and drug addicts who will take advantage of the procedure to obtain, by deception, quantities of the addicting compound.

In view of the above, the Board of Trustees recommends that the Association do not seek a change in the Federal Narcotic Law at this time.

G. Resolution on Advertising of Medical Products

In accordance with the directive of the House of Delegates in June, 1953, the Board of Trustees considered the Resolution on Advertising of Medical Products, introduced by Dr. W. C. Stover of Indiana, and makes the following report in this regard:

For almost 50 years the Council of Pharmacy and Chemistry has served as a standing committee of the Board of Trustees of the American Medical Association and in this capacity has exercised supervisory influence over the statements made in the advertising appearing in the publications of the American Medical Association. In fact, the principles which govern the acceptance of products for advertising in American Medical Association publications read in part:

> Medicinal preparations, to be admissible for advertising, must stand accepted by the Council on Pharmacy and Chemistry, except when such products may be determined by the Council as not coming within its purview.
>
> Apparatus or physical appliances used for therapeutic purposes must be accepted by the Council on Physical Medicine and Rehabilitation before being advertised in A. M. A. publications, except when such products may be determined by the Council as not coming within its purview.
>
> Food products for which health claims or special dietetic qualities are featured must be accepted by the Council on Foods and Nutrition to be eligible for advertising except when such products may be determined by the Council as not coming within its purview.
>
> Cosmetic preparations and soaps must stand accepted by the A. M. A. Committee on Cosmetics to be admissible for advertising.

Other principles read in part:

> Advertisements will not be accepted which, either by intent or inference, would result in deceiving, defrauding, or misleading the reader.
>
> Sweeping superlatives or unfair comparisons should be avoided. Any claims for superiority must be supported by sound evidence. Extravagantly worded copy is subject either to revision or to rejection.
>
> Quotations or excerpts from published papers are not accepted if by themselves they distort the true meaning intended by the authors, or are otherwise misleading.

All advertising concerning any products which fall within the purview of any standing committee of the Board of Trustees is referred to the office of the committee for comment and criticism before it is published. Comment is provided by the office on the basis of general opinions previously expressed by the committee and on the statements contained in advertising material already declared acceptable by the committee or council. Only then is the advertising, modified or otherwise, included in The Journal or any of the American Medical Association publications. It is not possible for the Editorial Department or the Advertising Department to pass on all advertising copy, and therefore the value of the Council's work in this respect is obvious.

Each council consists of members who are nationally or internationally known and who are considered experts in their fields. Collectively they are able to pass judgment on problems that might be subject to considerable difference of opinion if left to individual consideration. There are times when articles appear in a medical journal which would appear to be at variance with claims declared acceptable by the council; however, the councils give consideration to all published papers and to all of the evidence and for this reason are considered as giving generally acceptable advice. If anything, the councils have been accused of being too conservative. However, when one is dealing with potent drugs a conservative attitude is justified.

The Board of Trustees believes that the supervision exercised over the advertising in American Medical Association publications is in keeping with today's needs. It believes that the members of these councils provide sound and supportable opinions, and that such expert guidance offers as dependable assurance concerning advertising claims within the American Medical Association publications as is possible to achieve. At this time, no other effective system whereby advertising principles can be applied can be envisaged.

Report of Reference Committee on Hygiene and Public Health

Dr. Thurman B. Givan, Chairman, submitted the following report, which was adopted:

Resolution on Amendment of Federal Narcotic Act to Provide for Dispensing of Codeine Mixtures and Compounds on Oral Prescriptions: Your committee approves the recommendation of the Board of Trustees that the Association does not seek a change in the Federal Narcotic Law at this time.

Supplementary Report of the Board of Trustees on Advertising of Medical Products, and Resolution on Ethical Advertising: The supplementary report of the Board of Trustees on the Resolution dealing with advertising of medical products was carefully scrutinized and was discussed by several members, including Dr. Austin Smith, Editor of The Journal, and Dr. Robert Stormont, Secretary of the Council on Pharmacy and Chemistry. Your committee agree in principle with the resolution presented at this session by the West Virginia State Medical Association on the subject of ethical advertising but as a result of the discussion suggests the following recommendation: That the Council on Pharmacy and Chemistry be encouraged to take every opportunity to afford physicians early and complete information available on all drugs as they are produced, detailed or advertised, even before Council acceptance.

E. Resolution on "Doctor-Draft" Law

The resolution on the "Doctor-Draft" law, introduced in June, 1953, by Dr. A. H. Aaron of New York, proposing that the recommendations of state and local medical advisory committees to the Selective Service System be made mandatory rather than advisory, was considered by the Council on National Emergency Medical Service as directed by the House on recommendation of the Reference Committee on Legislation and Public Relations. It was the decision of the Council that its previous position be reaffirmed and that the proposal be not endorsed, and in this recommendation the Board of Trustees concurs. Experience has demonstrated that in the great majority of states the recommendations of the medical advisory committees are accepted by state and local Selective Service Boards. In addition, implementation of Dr. Aaron's proposal would require an amendment to the "Doctor-Draft" law. It is the opinion of the Board that such an amendment is neither necessary nor feasible at this time.

F. Medical Policies in Disaster

In 1938, following consideration of a request from the American National Red Cross for approval of medical policies in disaster, the House of Delegates agreed that the primary responsibility for the care of the sick and injured in disaster rests with the local physicians and dentists and that the functions of the Red Cross should be that of cooperation with local

physicians and dentists by assisting in organizing and directing medical relief work and by providing the needed facilities that are lacking for the emergency. With regard to detailed arrangements for emergency work it was decided that these could be made by mutual agreement between the Red Cross and local medical organizations so that a standard might be set in advance.

Believing that this policy should be reviewed in the light of the establishment of the Federal Civil Defense Administration, the Board of Trustees referred the matter to the Council on National Emergency Medical Service for study and report. The Council initiated correspondence with the two groups in order to obtain the present policies of the two agencies and to determine any overlapping of responsibilities which may exist.

It is the recommendation of the Board of Trustees that the House of Delegates adopt a position in agreement with the statement of the American National Red Cross that the primary responsibility for the care of the sick and injured in disaster rests with the public health authority and local medical and allied professional organizations. It is further recommended that the function of the Red Cross should be one of cooperation with local physicians and dentists and civil defense agencies. The Red Cross should assist in organizing emergency medical relief work and provide the facilities that may be lacking.

In general, the Board recommends the approval of the principles and practices outlined in current disaster policies of the Red Cross for the handling of the medical features of disaster relief. In view of the creation of federal, state, and local civil defense agencies, the development of uniform over-all plans is now feasible for national disaster. Detailed arrangements for possible emergencies could be made through agreements between the Red Cross, local medical organizations, and civil defense agencies so that a feasible program might be established in advance.

H. Universal Military Training Program

On Aug. 28, 1953, a statement prepared by the Council on National Emergency Medical Service and approved by the Board of Trustees was submitted to the National Security Training Commission. It is being presented to the House of Delegates at this time with the recommendation that the position recommended by the Association concerning the medical implications of a universal military training program may be affirmed. Affirmation of this statement does not in any way imply approval or disapproval of the establishment of a universal military training program.

Statement of the American Medical Association to the National Security Training Commission Aug. 28, 1953

In presenting this statement, it is the purpose of the American Medical Association to make certain suggestions relative to the medical aspects of universal military training rather than to comment on whether such a program should be adopted. If the Congress, in its discretion, determines that the program is necessary, the medical profession is ready to cooperate in its implementation. We believe that we can make a contribution at this time in connection with the preliminary planning for such a program, inasmuch as the various councils and departments of the Association have been studying for some time the factors involved in the most effective utilization of medical manpower in time of national emergency and in connection with universal military training.

Last year, representatives of the American Medical Association appeared twice before the National Security Training Commission and also testified before the Armed Services Committee of the Senate and the House of Representatives. The initial report of the commission, submitted to the Congress, covered certain of the Association's suggestions; however, others were not discussed. In our appearances before congressional committees there was a tendency to discuss many of our proposals in conjunction with legislation pending at that time designed to revise the Armed Forces Reserve Program. Although Congress did not adopt the commission's recommendations, the Armed Forces Reserve Act of 1952 was enacted on July 9, 1952. Inasmuch as the act does not cover the medical aspects of universal military training as discussed in our previous statements, it is apparent that if they are to be effected, they must be included in legislation which the commission may suggest for congressional consideration.

It is the belief of the Association that the following five cardinal elements essential to the health and medical care of our nation should be considered by the commission:

(1) *The Continuation of Pre-Professional and Professional Education for Qualified Students:* It has always been the firm belief of the Association that should a universal military training program be adopted, it is imperative that safeguards be included to prevent any disruption in the education of an adequate force of professional personnel. In order to accomplish the basic underlying purpose of Public Law 51, 82d Congress, i. e., to provide an adequate force of well-trained reserves, it is essential that the education of specialists be allowed to proceed without any impairment.

In its report to the Congress last year, the commission strongly recommended against split periods of training and the deferment of professional students from the six month training period. On page 28 of the report, the commission does, however, discuss the holding in abeyance of the reserve status "of a number of medical, dental and scientific students until the completion of their professional study." Inasmuch as this was one of the recommendations of the Association, we were pleased to see its favorable acceptance by the commission. However, the proposal was suggested by the commission for study only and was not included in the draft legislation which accompanied the report. With the rejection of split training periods and the deferment of professional students, this would appear to be the one remaining mechanism for insuring the uninterrupted flow of trained reserves. Therefore, the Association believes that it is imperative that this proposal be stressed by the commission in its new report and in its appearance before the congressional committees considering this legislation.

In this connection, two further points should be considered. The commission's report on page 28 also notes that: "Under such an arrangement, the Reserve obligation of seven and one-half years would not begin to run until *graduation from* medical, dental or scientific school." (emphasis added). It is believed that this recommendation should be changed to refer to completion of professional education rather than graduation from medical school. Such a revision would encompass the completion of internship and in some instances residency training. Such an amendment would appear to be in line with the thinking of the commission, in view of the following statement which appears in the same paragraph as the above quoted statement: "It would also provide the Armed Forces with reservists who were qualified doctors, dentists and technicians, instead of mere apprentices in these fields."

In the implementation of this recommendation, it is essential that no advantage over civilian hospitals accrue to Armed Forces hospitals by allowing internship and residency service in such installations to count against a person's total reserve obligation. If this were permitted, the obtaining of interns and residents by civilian hospitals would be made increasing difficult.

The American Medical Association sincerely believes that a person eligible for induction into the National Security Training Corps, whose aptitude or previous accomplishments indicate that he can best contribute to the nation as a trained professional man, should be placed in a category that will permit him to continue his education, and that such a person be so classified before or at the time he reaches the age of induction. It is also believed that the selection of students and the control of educational programs should remain in the hands of the individual colleges and universities.

(2) *The Performance of Preinduction, Induction, and Periodic Reserve Physical Examinations:* Neither Public Law 51, 82d Congress, nor the initial report of the commission specifies who will perform the induction and preinduction examinations for National Security Training Corps inductees, or the periodic physical examinations, while they are members of the reserve. If any attempt is made to perform these examinations by using full-time medical personnel of the armed forces, it will be necessary to call into service a much larger number of phy-

sicians than is currently required. The possibility of a shortage of medical personnel for the civilian population of the country which might result from such a course of action can be averted. We would like to restate our earlier recommendations that such examinations be conducted by civilian physicians on a fee basis, or by reserve personnel for the purpose of maintaining a satisfactory reserve status. This system is now operating successfully with respect to the conducting of periodic physical examinations for reservists by the armed forces.

(3) *Extent of Medical Services to Be Provided for Members of the National Security Training Corps: (a) Corrective Treatment and Rehabilitation:* The American Medical Association thoroughly supports the concept that those individuals who cannot meet the physical and mental requirements established for induction into the National Security Training Corps, should, when possible, be rehabilitated, but it equally strongly opposes the idea that this responsibility belongs to the federal government. The original version of s. 1, 82d Congress, contained a section providing for the assumption of corrective treatment and rehabilitative care by the federal government. The Association feels that the deletion of this section by the Congress prior to the enactment of s. 1 into law is indicative of congressional intent in this regard.

(b) Medical Care During Period of Basic Training: The treatment of injuries and sickness arising during or as a direct result of military service while in the National Security Training Corps will, of course, be a responsibility of government. It is believed that such treatment should be the same as that furnished currently to personnel of the armed forces. It is believed, however, that in light of the extremely short period of training and the favorable conditions which will prevail (i. e., no overseas assignments, no combat duty, etc.), the number of doctors per 1,000 inductees should not exceed the accepted requirements for the civilian population generally. Further, it is believed that whatever additional medical personnel is required should be obtained without enlarging the regular complement of the medical corps of the three services. With respect to the reserve personnel which will be recalled in this connection, it is recommended that a rotation system be adopted with short terms of active duty required.

(4) *Eligibility of Members of National Security Training Corps and Reserve Components for Veterans' Medical Benefits:* Though there are a variety of benefits presently available to wartime and peacetime veterans which may or may not be extended to the members of the National Security Training Corps, the American Medical Association would like to comment only with respect to medical and hospital benefits for non-service-connected disabilities. Existing provisions of law permit the treatment of certain non-service-connected disabilities in Veterans Administration facilities for persons "including veterans who served, regardless of length of service, during a period of war, (*a*) if they were discharged under conditions other than dishonorable; and (*b*) who swear that they are unable to defray the expenses of hospitalization."

In this connection, the Association is unalterably opposed to any suggestion which contemplates the extension of such care for non-service-connected conditions to members of the National Security Training Corps or other peacetime veterans. The use of the Veterans Administration facilities for such purposes would create a need for additional facilities and increased medical staffs, thereby adding to the growing strain upon the health and medical manpower resources of the nation created by the existing emergency.

The American Medical Association is in agreement with the recommendation contained in the initial report of the National Security Training Commission concerning the status of trainees with respect to veterans' medical benefits.

(5) *Source and Selection of Medical and Allied Professional Personnel:* There is considerable concern in the medical profession as to the manner of selecting the medical and allied personnel necessary to man a universal military training program and the proper agency to determine the extent of the need. This concern is predicated in a large measure on the fact that under the present proposal, all men on reaching the age of induction will be required to take basic military training and remain in a reserve component of the armed forces for seven and one-half years.

The American Medical Association is in favor of the establishment of a national civilian board, or a comparable agency, to insure the proper distribution of medical and other health reserves between civilian and military needs. Unless this is done, it will be extremely difficult to insure that such individuals serve in a manner which will contribute the most to the strength of the nation.

I. Dependent Medical Care

During the past months the Board of Trustees, as well as the Council on National Emergency Medical Service, the Council on Medical Service, and the Council on Medical Education and Hospitals, has considered the important subject of medical care for dependents of service personnel. The Board of Trustees, after reviewing a resolution on this subject from the Council on National Emergency Medical Service, submits the following statement to the House of Delegates so that a firm policy may be established by the Association in this regard:

The American Medical Association is desirous that the highest quality of medical care be provided and maintained for the entire population, including dependents of military personnel. This goal can only be realized through the greatest possible utilization of civilian community medical personnel and facilities rather than through the use of federal medical installations. The present practice of providing medical care for dependents of service personnel operates to the detriment of the community medical program. An additional result is the unnecessary and exceedingly costly expansion of military medical facilities, which, when combined with other federal medical programs, has resulted in an artificial shortage of medical and allied health personnel.

The Board, therefore, recommends that the House of Delegates adopt the following policy with respect to dependent medical care and that copies of this statement be forwarded to the President, the Secretary of Defense, and the Chairmen of the armed services committees of the Senate and the House of Representatives:

(*a*) That Congress be urged to consider carefully to define fully a national policy with respect to the provision of medical care for dependents of service personnel;

(*b*) That the Association advocate that any program devised for the care of dependents of military personnel be made contingent on the adoption of a clear and understandable definition of what constitutes a dependent;

(*c*) That the Association continue to recognize the need and importance of utilizing military medical personnel and facilities in providing hospitalization and medical care for dependents of service personnel residing outside the continental United States, and at or near military posts in the United States where civilian facilities are unavailable or inadequate;

(*d*) That except in situations as outlined in (*c*) above, the Association recommend that medical care and hospitalization of the dependents of service personnel be provided by civilian personnel in civilian facilities; and

(*e*) That the Association approve of the principle of premium payments by service personnel through the media of nongovernmental insurance agencies to cover the cost of medical and hospital care of their dependents through voluntary payroll deductions.

J. Report of Citizens' Advisory Commission on Medical Care of Dependents of Military Personnel (Moulton Commission)

At its meeting on Oct. 31 and Nov. 1, 1953, the Council on National Emergency Medical Service reviewed in detail the report of the Citizens' Advisory Commission on Medical Care of Dependents of Military Personnel (Moulton Commission), as well as statements from representatives of the various organizations and councils of the Association interested in the subject of dependent medical care, and submitted its recommendations to the Board of Trustees. The Board approved the report of the Council and presents the following statement with the recommendation that it be adopted by the House of Delegates:

The Board is of the opinion that the Citizens' Advisory Commission on Medical Care of Dependents of Military Personnel, under the chairmanship of Harold G. Moulton, was given insufficient time to investigate the many complex problems and issues involved in the provision of medical care for dependents of service personnel and that the commission has failed to take cognizance of the broad socialistic implications of this problem and the fact that a perpetuation or an extension of the present program transcends the interests of the Department of Defense.

In the commission's report complete emphasis has been placed on the justification and expansion of the present system rather than on determining the need for and the best method of providing dependent medical care. Also left unanswered is the question as to the extent of such dependent medical care and the serious consequences of drafting physicians under a discriminatory draft law to perform services for other civilians.

The conclusions contained in the report are not sufficiently explained or documented by substantial evidence and the recommendations would, if adopted, completely reverse the universally accepted position that civilian facilities, if available and adequate, should be utilized first and that the use of military facilities should be restricted to emergency situations and to overseas or remote areas.

The Board therefore recommends that the House of Delegates register its disagreement with the substance of the recommendations of the Moulton Commission and that its views be communicated to the Secretary of Defense and to the chairmen of the armed services committees of the Senate and the House of Representatives.

It further recommends that the newly established Commission on Organization of the Executive Branch of the Government, under the chairmanship of former President Herbert Hoover, be requested to consider the subject of dependent medical care, that the matter be thoroughly and exhaustively studied, and that the Congress be supplied with complete background and statistical information, as well as a discussion of the broad implications of the program, so that a sound national policy can be established.

Report of Reference Committee on Medical Military Affairs

Dr. William A. Hyland, Chairman, submitted the following report, which was adopted:

Resolution on "Doctor-Draft" Law: The report as presented by Dr. Murray states: The resolution on the "Doctor-Draft" law, introduced in June, 1953, by Dr. A. H. Aaron of New York, proposing that the recommendations of state and local Medical Advisory Committees to the Selective Service System be made mandatory rather than advisory, was considered by the Council on National Emergency Medical Service as directed by the House on recommendation of the Reference Committee on Legislation and Public Relations. It was the decision of the Council that its previous position be reaffirmed and that the proposal be not endorsed, and in this recommendation the Board of Trustees concurs. Experience has demonstrated that in the great majority of states the recommendations of the Medical Advisory Committees are accepted by state and local Selective Service boards. In addition, implementation of Dr. Aaron's proposal would require an amendment to the "Doctor-Draft" law. It is the opinion of the Board that such an amendment is neither necessary nor feasible at this time.

Your reference committee approves the decision of the Council, in which the Trustees concur, that the proposal be not endorsed owing to the fact that the implementation of Dr. Aaron's proposal would require an amendment to the "Doctor-Draft" law, it being the opinion of the Board that such an amendment is neither necessary nor feasible at this time.

Medical Policies in Disaster: Your committee recommends that the first sentence of the third paragraph be changed from "It is the recommendation of the Board of Trustees that the House of Delegates adopt a position in agreement with the statement of the American National Red Cross that the primary responsibility for the care of the sick and injured in disaster rests with the public health authority and local medical and allied professional organizations," to read: "It is the recommendation of the Board of Trustees that the House of Delegates adopt a position in agreement with the statement of the American National Red Cross that the primary responsibility for the care of the sick and injured in disaster rests with local physicians and allied health personnel." It is further recommended that the first sentence of the fourth paragraph become the last sentence of the third paragraph.

Universal Military Training Program: The report, as read by Dr. Murray, reads: "On Aug. 28, 1953, a statement prepared by the Council on National Emergency Medical Service and approved by the Board of Trustees was submitted to the National Security Training Commission. It is being presented to the House of Delegates at this time with the recommendation that the position recommended by the Association concerning the medical implications of a Universal Military Training program may be affirmed. Affirmation of this statement does not in any way imply approval or disapproval of the establishment of a Universal Military Training program."

These medical implications referred to are: (1) The continuation of preprofessional and professional education for qualified students; (2) The performance of pre-induction, induction, and periodic reserve physical examinations; (3) Extent of medical services to be provided for members of the National Security Training Corps: (*a*) corrective treatment and rehabilitation, and (*b*) medical care during period of basic training; (4) Eligibility of members of National Security Training Corps and Reserve components for veterans' medical benefits; and (5) Source and selection of medical and allied professional personnel.

Dependent Medical Care: Your committee recommends the substitution of the word "method" for "practice" in the third sentence of the second paragraph, and substitution of the word "disadvantage" for "detriment" in the same sentence. Under (e) your committee recommends substitution of the word "mechanism" for "principle."

Your reference committee wishes to emphasize with respect to this proposal that the policy advocated should not in any way be construed as one of opposition by the American Medical Association to dependent medical care. As stated in the report, the recommendation is made that the Congress determine whether such care should be provided. The position recommended refers only to the manner in which it should be provided if it is determined by the Congress to be a proper emolument of military service.

Report of Citizens' Advisory Commission on Medical Care of Dependents of Military Personnel: Your committee recommends deletion of the word "socialistic" in the last phrase of the second paragraph, and that in the middle of the fourth paragraph the word "generally" be substituted for "universally."

L. Donation to American Medical Education Foundation

The Board contemplates another donation of $500,000 to the American Medical Education Foundation for the year 1954. With this contribution the American Medical Association will have spent 2 million dollars for aid to the medical schools of the country. However, the Board wishes to call to the attention of the House that the financial status of the Association is such that a similar contribution cannot be continued indefinitely. Such an annual appropriation would soon become a matter of concern to the Board of Trustees in its effort to maintain a balanced budget. Consequently the Board strongly urges the continued and increased support of medical schools by the individual physician and by organizations in medical and allied fields.

M. Report of Committee on Specialists in Other Fields

The Joint Committee of the Board of Trustees and the Council on Medical Education and Hospitals, appointed at the direction of the House of Delegates to study the relationship of American medicine to professional nonmedical groups in the health field, reported that it believes that the entire

matter is of such importance that a small ad hoc committee will not do justice to the problem. The committee therefore recommended that (1) the Board of Trustees and the Council on Medical Education and Hospitals and its staff, in association with the appropriate councils and bureaus of the American Medical Association and relevant professional groups, undertake a detailed investigation of all facets of the problem and (2) following the receipt by the committee of a report from the Council on its findings and recommendations, the Committee on Specialists in Other Fields will submit a report of its recommendations to the Board of Trustees.

The Board concurs in the recommendations of the commitee and requests the indulgence of the House of Delegates until a further report is received from the committee.

Report of Reference Committee on Medical Education and Hospitals

Dr. James Z. Appel, Chairman, submitted the following report, which was adopted:

Donation to the American Medical Education Foundation: The announcement by the Board of Trustees concerning the contemplation of another gift of $500,000 to the American Medical Education Foundation in 1954 is pleasing to note. Its warning that such annual gifts cannot continue indefinitely is most timely. It presents an added challenge to the medical profession as individuals to accept the obligation owed by each and every physician to the institution that has made his success in life possible. Without the instruction and training given to each of us by our respective medical schools at approximately one-third its cost, our station in life, our homes, and the benefits we give our children would not be possible. It is, therefore, a personal and family responsibility, not one for the profession at large. Doctors accept this challenge. This can be accomplished either by voluntary contributions or, if the constituent societies desire, by assessment. This latter method has been successfully demonstrated by the Illinois State Medical Society, whose membership should be complimented for their generosity.

Report of Committee on Specialists in Other Fields: The supplementary report of the Board of Trustees concerning specialists in nonmedical fields is simply informative and requires no action.

Messages Regarding Dr. George W. Kosmak and Dr. Charles H. Phifer

The Speaker announced that he had received a letter from Dr. George W. Kosmak regretting his inability, because of ill health, to attend the St. Louis Meeting, especially since this session would terminate his many years of service as delegate from the Medical Society of the State of New York.

It was also announced by the Speaker that Dr. Charles H. Phifer, delegate from the Illinois State Medical Society, and a member of the Council on Scientific Assembly, was unable to come to St. Louis because of illness.

The House of Delegates, by unanimous vote, instructed the Secretary to telegraph to Drs. Kosmak and Phifer the greetings and best wishes of the House.

Report and Supplementary Report of the American Medical Education Foundation

Dr. Louis H. Bauer, President, presented the report of the American Medical Education Foundation (see THE JOURNAL, Nov. 7, 1953, pages 956-957) and the following supplementary report, both of which were referred to the Reference Committee on Medical Education and Hospitals:

The report of the American Medical Education Foundation made to this House and printed in the Handbook of the House of Delegates was made as of July 1953. There have been some important changes in the status of the foundation since that report was rendered and for that reason this amended report is being made.

The income of the foundation now totals $1,000,174.00. This is worthy of note because it is the first time that the annual income has exceeded a million dollars since the inception of the foundation in 1950. This new total was made possible by the generous gift of the American College of Radiology, which renewed its support of this program with a gift of $2,000. Worthy of mention at this time also is the fact that the number of contributors to the foundation now exceeds the 1952 total by more than 200% (16,475 vs. 7,259 for 1952). The dollar amount received from individual contributors, mostly physicians, exceeds last year by approximately 50% and the gross total approximates a 15% increase over 1952. During the current year, with 65 of the 79 medical schools reporting their direct contributions, individual physicians in the United States have given $782,885 directly to their medical schools. This sum has been given by 22,273 individuals. At a regular meeting of the board of directors of the foundation the following were elected to serve as officers of the foundation or members of the board of directors: Dr. Louis H. Bauer, New York, was elected to the office of president, succeeding Dr. Elmer L. Henderson, deceased; Dr. George F. Lull was elected vice president, and Dr. Edward L. Turner, Secretary of the Council on Medical Education and Hospitals of the American Medical Association, was elected secretary-treasurer to fill the vacancy created by the resignation of Dr. Donald G. Anderson, dean, University of Rochester School of Medicine. Dr. Anderson, who served as secretary-treasurer of the foundation since its inception, was elected a member of the board of directors.

Report of Reference Committee on Medical Education and Hospitals

Dr. James Z. Appel, Chairman, submitted the following report, which was adopted:

Report of the American Medical Education Foundation: It is gratifying to note that the income of the American Medical Education Foundation now totals $1,000,174 and that the number of contributors to the foundation now exceeds the total for 1952 by more than 200% (16,475 vs. 7,259 for 1952). Likewise $782,885 has been given by individual physicians in the United States directly to their medical schools. In addition, recognition should be given to the American Medical Association for underwriting this foundation to the extent that every penny donated by a physician goes to a medical school.

Report of Judicial Council

Dr. Edward R. Cunniffe, Chairman, presented the following report of the Judicial Council, which was referred to the Reference Committee on Miscellaneous Business:

Since the interim meeting held in Denver in December, 1952, the Judicial Council has held four meetings divided into 14 sessions; 4 in conjunction with the annual meeting, 5 during the present clinical meeting, and the remainder at headquarters in Chicago. At these meetings routine business was transacted which included the recommendation of candidates for affiliate membership and consideration of many requests for decisions and opinions concerning ethical problems. In some instances, to insure prompt replies to inquirers, the Chairman of the Council gave personal, provisional opinions which were reviewed by the Council at subsequent meetings. Two appeals from decisions of constituent associations were heard by the Council. The following illustrate some of the questions which have been presented to the Council and the Council's action.

In the report of the Council submitted to the House of Delegates in December, 1952, it was stated that "the number of requests addressed to the Council for specific interpretations of the Principles of Medical Ethics continues to be ever increasing." This situation still prevails. The Council has no desire to avoid work which should legitimately come before it, but it has gained the impresison that many members of the Association do not fully grasp the real function of the Judicial Council in the proper administration of certain affairs of the Association. The Judicial Council is not an agency created to police the medical profession and enforce the Principles of Medical Ethics. The Bylaws of the Association vest in the Judicial Council the "judicial power" of the Association. This is authority to hear and determine issues presented to it but not to enforce or prosecute for violations.

It is true that the Council has jurisdiction over all matters of professional ethics, but this jurisdiction does not apply to the determination of the many ethical questions which often occur to the 140,000 or more members of the Association—it only applies to controversies. The Council was not created as a listening post for the purpose of airing discussions of abstract ethical problems. It is earnestly to be desired that individual members of the Association who question the ethics of some phase of their own or a colleague's practice should first submit their problems to the proper official body of their component medical society for a decision at the local level based on local custom and usage and local standards of practice. If this procedure is followed, only actual controversies will be presented to the Council and the proper work of the Council may be carried out more expeditiously.

Transfer of Membership

The Council has had numerous appeals from individuals regarding transfer of membership from one constituent association to another. Occasionally they have been unable to obtain membership in the component or constituent association to which they have applied for transfer despite the fact that they have been members in good standing of the American Medical Association. Many of these appeals have not been accompanied by all the information needed by the Council to enable it to render a decision. Some of the county and state organizations have failed to present complete membership data necessary for evaluation by the Council. This has resulted in the expenditure of unnecessary effort while obtaining facts pertaining to certain situations, and many times the Council has been unable to make a satisfactory decision due to the inadequacy of reports. These difficulties could be obviated if the county and state organizations would furnish a comprehensive summary of the membership activity of the applicant. This information would be of great value to the Council for many reasons. The prompt completion of this transfer is of vital importance to both the member and the American Medical Association, for if it is not completed in six months the applicant loses his membership in the American Medical Association and all the privileges attendant thereto. When a properly approved request for transfer is denied, the applicant can appeal to the Judicial Council. This privilege has been a tradition in our Association for many years.

Statement of Ownership of Pharmacy

The Council has had many inquiries regarding the ownership of pharmacies by physicians. The Principles of Medical Ethics are very clear in regard to this matter. Section 6, Chapter I of the Principles provides that "An ethical physician does not engage in barter or trade in the appliances, devices or remedies prescribed for patients, but limits the sources of his professional income to professional services rendered the patient." The Council has ruled that it is unethical for a physician to have a financial interest in a pharmacy in the area in which he conducts his professional activities and where he profits directly or indirectly from the sale of devices or remedies prescribed for his patients. This is particularly true when the services of other reputable pharmacies are readily available. Along with the problem of ownership of pharmacies by doctors may be considered the question of rental of space to a pharmacist in a clinic or office building owned or leased by physicians. When physicians rent such space on a sliding scale or for a percentage of the income received by the pharmacy the result is equivalent to receiving a rebate from the prescription and is therefore unethical.

The Purveyal of Medical Services

There have been many inquiries regarding the employment of physicians by hospitals. Most of them pertain to practices of anesthesiologists, radiologists, pathologists, and physiatrists.

The Council has repeatedly stated that the acceptance of a salary by a physician does not of itself constitute unethical conduct. This opinion is predicated on the Council's interpretation of the Principles of Medical Ethics, particularly Section 6, Article VI, Chapter III entitled, "Purveyal of Medical Services." It is the opinion of the Council that this section is a clear, unambiguous enunciation of a principle, and that any uncertainty associated with the principle stems from failure to understand and appreciate that it must be applied to a specific factual situation.

The issue to be resolved then is factual. If, in a given situation, a physician disposes of his professional services under terms which permit exploitation, his conduct is unethical. Knowledge of the facts, however, may reveal that there is not exploitation; that there is not an unethical division of fees; that there is not a denial of free choice of physician as defined by the Principles or that the arrangement does not cause a deterioration of the quality of medical services.

The Judicial Council believes that the "Relation of Physicians and Hospitals" (Guides for Conduct of Physicians in Relationships with Institutions) and the "Report of the Joint Committee on Hospital-Physician Relationships of the Boards of Trustees of the American Medical Association and American Hospital Association" make it abundantly clear that when such questions arise their solution depends on an analysis of the factual situation which obtains in each relationship. Each of these reports reaffirms in its own language existing ethical principles. Each suggests that solutions of controversies relating to financial arrangements can best be effected at the local level. Each emphasizes that the question of ethics involved in establishing terms by which a physician may dispose of his professional attainments or services depends on whether they are exploited and whether any other principle of ethics is involved.

Acceptance of Council Rulings

The Principles of Medical Ethics of the American Medical Association provides the basis on which are predicated all principles of medical ethics, which are utilized to guide the activities of physicians. The fact that a physician is a member of a specialty group or of a constituent association where special interpretation of ethical principles has been provided does not release him from his obligation to comply with the Principles of Medical Ethics of the American Medical Association. When classified special societies request a ruling of the Council on behalf of their membership on the Principles of Medical Ethics, it is the duty of the membership of that particular society to accept the ruling of the Judicial Council of the American Medical Association as final.

The Principles of Medical Ethics May Be Amended Only by Vote of the House of Delegats of the American Medical Association

There have been instances in which a state association or a specialty organization has announced an interpretation of a segment of the Principles of Medical Ethics which is definitely contrary to that adopted by the American Medical Association. The Judicial Council wishes to emphasize that the only method by which the Principles of Medical Ethics of the American Medical Association may be altered requires the formal presentation of a resolution to the House of Delegates of the American Medical Association embodying an amendment to the Principles of Medical Ethics. When the proposed revisions are properly presented, they will receive appropriate consideration and when reported by the reference committee will be subject to discussion and vote by the House of Delegates. They may, however, be referred to the Council on Constitution and Bylaws. The adoption and broadcasting of so-called principles of medical ethics by any other process by any other society or organization is to be condemned.

Conclusion

In closing this report to the House of Delegates, your Judicial Council solicits the most careful consideration by the members of the House and their constituency of 140,000 physicians to the loss of public confidence in the integrity of the medical profession that follows each publicized expression of personal opinion regarding unethical conduct alleged to be currently prevalent in considerable segments of the nation. We have the constitutional processes by which charges of unethical conduct may be tried in an atmosphere of equity and fair play. Why not invite formal charges of misconduct among

members, and thereby insure each alleged offender trial by his peers rather than by sources that lead no further than to sensationalism and loss to our profession of the precious good will of the public?

Report of Reference Committee on Miscellaneous Business

Dr. H. Gordon MacLean, Chairman, presented the following report, which was adopted:

Report of the Judicial Council: Your committee reviewed the report of the Judicial Council and considered with great interest the various topics on transfer of membership, statement of ownership of pharmacy, the purveyal of medical services, and acceptance of council rulings. Your committee approves this report of the Judicial Council and recommends its adoption.

Report of the Council on Medical Education and Hospitals

Dr. H. G. Weiskotten, Chairman, presented the report of the Council on Medical Education and Hospitals (see THE JOURNAL, Nov. 7, 1953, pages 941-947), which was referred to the Reference Committee on Medical Education and Hospitals.

Report of Reference Committee on Medical Education and Hospitals

Dr. James Z. Appel, Chairman, submitted the following report, which was adopted:

Report of the Council on Medical Education and Hospitals: Your committee has carefully reviewed the report of the Council on Medical Education and Hospitals. Your committee wishes to call attention to that section of the report commenting on the National Commission on Accreditation. The Council is to be congratulated on keeping informed on this development and for its success in being formally recognized as one of the two agencies best fitted to establish standards and accredit programs in the field of medicine. It must be remembered that this does not close the issue.

It is further noted in the report that the Council recognizes the problem of evaluating the education and preparation of physicians who attended foreign medical schools and has informed your committee that it has instituted a continuing study of the problem.

In its report the Council has presented for approval by this House of Delegates two sets of essentials for technical schools. (1) Your reference committee has studied the "Essentials for the Training of Medical Record Technicians," which were temporarily approved by the House of Delegates in June, 1953. Your committee would like to point out that these essentials are incorrectly referred to as "Essentials for the Training of Medical Record Librarians" and should be referred to as "Essentials for the Training of Medical Record Technicians." With this correction, your reference committee recommends the approval of these essentials. (2) The Council also asks for approval of revised "Essentials of an Acceptable School of Medical Technology." Your reference committee has studied these revised essentials, has noted the alterations from the previous essentials, and recommends that the revised essentials be approved.

Your reference committee believes it desirable in this year's report to comment on the position which the Council on Medical Education and Hospitals occupies in the area of establishing and enforcing educational standards in medicine and related fields. Those who are not familiar with the history and traditions developed by the Council over a period of 50 years, with the support and encouragement of the House of Delegates, frequently assume that the Council's chief function is to protect the interests of the medical profession against any movements in medical education that physicians may feel are inimical to their personal interests. It is well known that the uninformed have often charged the American Medical Association with attempting through the activities of the Council to limit the number of physicians trained in this country. From time to time other less well-defined calumnies are advanced to support claims that the medical profession as such should have no voice in the establishment or enforcement of the educational standards. This attitude, which is unfortunately encountered too often, is potentially a dangerous one. The Council has recognized this danger and has constantly rededicated itself to the belief that it should at all times maintain maximum objectivity and that at all times in establishing and enforcing the standards it should be guided by the simple criterion of what is best for the public and what is best for medical education. Through the years the Council has striven, and your reference committee believes with success, to maintain this position even though it has at times brought serious criticism on the Council from small or large segments of the medical profession who fear personal inconvenience from the Council's actions. The Council has endured this criticism because it believes that the medical profession's legitimate interest and important influence in the maintenance of high standards of medical education can be preserved only so long as universities, medical schools, hospitals, and the general public have confidence that the profession's designated agency in educational matters, the Council, is free to devote itself to the support of sound principles of education and the welfare of society. It believes that the attainment of these objectives is also in the best interest of the welfare of the profession itself. Your reference committee feels certain that the House of Delegates appreciates the importance of this view and will support the Council in maintaining it.

A related problem that may be appropriately discussed at this time is the relationship of the Council's standards to the laws or regulations of individual states. On occasion in the recent past, the view has been advanced that the Council should not adopt any standards for the approval of institutions that are in conflict with the laws or regulations of any state. This is an untenable position. Its acceptance would mean that the Council could not raise standards above those of the state having the lowest standards. Approval by the Council is a voluntary, unofficial matter which must be requested by the individual institution. If an individual state imposes restrictions on a class of institution that will not permit them to meet the Council's standards, the institutions so affected have the choice of not seeking the Council's approval or working for a modification of the laws or regulations that prevent them from meeting the Council's standards. Your reference committee feels certain that it has the support of the House of Delegates on this fundamental issue because otherwise the Council would be powerless to have any influence on educational standards on a national basis.

The Council is also charged with the responsibility of inspecting and approving hospitals in their functions as agencies for graduate training. It is the belief of your reference committee that this activity directly improves the quality of medical service available to the public. Furthermore, it increases the effectiveness of the profession in its responsibility for the care and prevention of ill health.

Your reference committee recommends that the report of the Council on Medical Education and Hospitals be approved.

Report of Council on Scientific Assembly

Dr. Samuel P. Newman, member, presented for Dr. Henry R. Viets, Chairman, the following report of the Council on Scientific Assembly, which was referred to the Reference Committee on Sections and Section Work:

To the Members of the House of Delegates of the American Medical Association:

Since the report given at the 1952 Clinical Meeting, the Council on Scientific Assembly met on Feb. 2, 1953, in New York, on May 31, 1953, also in New York, and on Oct. 19, 1953, in Chicago. Informal meetings were held in St. Louis on May 4 and on July 15 in Chicago, and the Council met with the Section Secretaries in Chicago on Oct. 20, 1953. The chairman also met with the officers of the Dade County

Medical Society in Miami, Nov. 11 and 12, for a preliminary consideration of the program for the Clinical Meeting to be held in Miami in December, 1954. The chairman also visited a number of medical schools in the South and Southwest for consultations with the deans and the faculty regarding the composition of the Miami program. The usual business was conducted at the various meetings of the Council with the principal emphasis being placed on program construction, integration with the activities of the Section Secretaries, a free interplay between the Council and the Committee on Scientific Exhibit and, in general, a drawing together of many divisions of the Scientific Assembly under the general guidance of the Council.

Denver Clinical Meeting

The Denver meeting was well attended; in some instances there were more persons at the General Assemblies than at the Annual Meeting in Chicago, held the previous June. The clinical presentations were also better attended than were some of the Section meetings in Chicago. The high rate of registration from Colorado and adjacent states, plus the enthusiasm shown by the physicians attending the individual sessions, gave sound evidence of the value of the Clinical Meeting to practitioners in areas of the country where the Annual Meeting could not be held because of limited accommodations. The Council is fully aware of the great educational opportunity provided by the Clinical Meetings and in building its programs quality has always been the first consideration both in the Assembly and in the exhibits. The Council would consider it appropriate to think in terms of regional areas rather than states when planning meetings in the future, lest the Clinical Meeting of the American Medical Association become a "glorified state meeting," rather than one embracing larger sections of the country, such as the Northwest, the Southwest, New England, etc. The Council noted with pleasure the activities of the Woman's Auxiliary in Denver and felt that their cooperation contributed greatly to the success of the meeting. It was suggested that this aspect of the Clinical Meeting might be more extensively developed at future meetings.

New York Annual Meeting

The meeting presented no unusual features as far as the program was concerned except the panel discussion in the General Scientific Meetings Friday morning on "Today's Medicine for Tomorrow's Patient." In spite of the large total registration, the audience was surprisingly small, again illustrating the difficulty of reaching a full attendance on the last day of the meeting even when an exceptional program is provided. The Section meetings in New York were fairly well attended. The upward trend in attendance noted in the last few years continued, although some of the Sections drew smaller numbers than in the past. No Section, however, fell to such a low level in attendance that its discontinuance was considered.

Future Meetings

Plans for the San Francisco Annual Meeting are well formulated. In most instances the Section Secretaries were able to report on a completed program when the Council met with them in an all day session in Chicago on Oct. 20, 1953. The Council suggested that a brief business meeting be held on the first day of the Section meetings, in addition to the regular business meeting on the second day, for the purpose of presenting resolutions which the Section may wish its delegates to introduce in the House of Delegates.

Reorganization Plan

Since January, 1948, when the first Clinical Meeting of the American Medical Association was inaugurated, the Council has been giving primary consideration to the preparation of programs for both the Annual and Clinical Meetings. Through the year 1953, including the St. Louis Meeting, 13 such programs have been arranged. Based on the experience of the Council during this period and after full consideration, the Council is now of the unanimous opinion that a reorganization plan should be considered at this time. The principal changes would be as follows:

1. The Council on Scientific Assembly should become a committee of the Board of Trustees, rather than a committee of the House of Delegates.
2. The Council on Scientific Assembly should incorporate into its structure the Committee on Scientific Exhibit.
3. A permanent office should be established at American Medical Association headquarters with a full-time secretary to carry on the activities of the Council as reorganized.
4. The Council should be enlarged from seven members to ten.
5. The Council on Scientific Assembly, constituted as above, would be able to set up separate committees on scientific exhibits, television, motion pictures and association exhibits, and a general program committee for both the Annual and Clinical Meetings.
6. The functions now carried on by the Council, other than arranging the programs, would be retained.
7. Report of the Council's activities would become part of the Report of the Board of Trustees and would still be subject to action by the House of Delegates.
8. The chief reason for reorganization is to aid in coordinating the functions of the Council with those of the Committee on Scientific Exhibit and other related components of the American Medical Association headquarters having to do with the Scientific Assembly.
9. If the plan is adopted, appropriate changes in the Bylaws will be necessary.

Miscellaneous

The Council voted to allot a Session on Legal Medicine and a Session on Allergy in the Section on Miscellaneous Topics for the San Francisco Annual Meeting. For the San Francisco Meeting, it was voted to revert to the former practice of holding the General Scientific Meetings all day on Monday and on Tuesday morning. The Section meetings will begin on Tuesday afternoon and continue through Friday morning.

The Council noted with regret the death of two former members, Drs. Frank H. Lahey and Alfred A. Walker. Dr. Lahey served the Council for ten years, from 1927 to 1937. Dr. Walker was a member from 1935 to 1945 and chairman from 1942 to 1945. Both contributed to the growth of the Council and brought the Scientific Assembly to a high standard through their devotion to the best interests of the American Medical Association.

Report of Reference Committee on Sections and Section Work

Dr. Jesse D. Hamer, Chairman, presented the following report, which was adopted:

The report of the Council on Scientific Assembly was reviewed by your committee, wherein it was noted with satisfaction the report submitted by this council concerning the quality of the programs displayed at the Denver Clinical Meeting last December and the New York Annual Meeting in June, 1953. It was noted also that plans are now well under way for the scientific program that will be presented in San Francisco next June and at the Miami Clinical Meeting in December, 1954.

Attention is called to this House by your committee to a consideration of the report of the Council on Scientific Assembly wherein a reorganization plan concerned with the Council and the Bureau of Exhibits is suggested. Your committee heard several representatives of both the Council on Scientific Assembly and the Bureau of Exhibits, all of whom expressed the desire that this reorganization plan begin the process of activation. No one appeared before your committee in opposition to this proposed plan.

Your committee recommends that the proposed reorganization plan affecting these two departments be accepted by this House in principle, and that it be referred to the Board of Trustees for further implementation.

Report of Council on Medical Service

Dr. Elmer Hess, Chairman, presented the report of the Council on Medical Service (see THE JOURNAL, Nov. 7, 1953, pages 947-955), which was referred to the Reference Committee on Insurance and Medical Service:

Supplementary Report of Council on Medical Service

Dr. Elmer Hess, Chairman, presented the following supplementary report of the Council on Medical Service, which also

was referred to the Reference Committee on Insurance and Medical Service:

To the Members of the House of Delegates of the American Medical Association:

Following out the directives of the House of Delegates, which are found in the Council's report, the Council on Medical Service wishes at this time to submit the following supplemental report:

Four regional conferences concerning the policy of the American Medical Association with respect to veterans' medical care have been held by the Council's Committee on Federal Medical Services. These conferences, held in New York, Washington, Atlanta, and Dallas, were well attended by representatives of the 20 state medical associations invited.

The purposes of these conferences were: (1) to develop a working liaison with state association veterans' committees; (2) to discuss methods for carrying out the instructions of the House of Delegates; (3) to increase the number of physicians who have a working knowledge of the policy and the facts relating to it; and (4) to learn the situation in each state.

It is the consensus of the committee and the staff members attending these conferences that they were most successful in accomplishing the above listed purposes. In view of this, the Council recommends that, as soon as possible, similar regional conferences be held in those areas of the country not previously covered so that all states may be included. The Council further recommends that the House urge each state medical association to take formal action approving the policy statement on medical care for veterans with non-service-connected disabilities as adopted by the House in June, 1953. Finally, the Council recommends that it be authorized to develop liaison, through its Committee on Federal Medical Services, with national and local organizations interested in and concerned with veterans' medical care.

The Council would also like to take this opportunity to commend the chairman and members of the Committee on Federal Medical Services and the panel members participating in these conferences for the excellent manner in which they have been carrying out the directives of the House of Delegates.

Report of Reference Committee on Insurance and Medical Service

Dr. John M. Porter, Chairman, submitted the following report, which was adopted:

The work of the Council on Medical Service is of such tremendous scope and covers such varied fields that your committee and no doubt the House of Delegates has difficulty in appreciating all that has been done by the Council and its committees. Commendation and thanks are certainly in order to its chairman, its secretary, and all its members, who could not have accomplished what they have without tremendous sacrifice of time and effort. The work of the Council is reported in seven sections, corresponding to the actions taken by the different committees. Since there is some overlapping, the report of your reference committee will not follow these sections exactly.

In the matter of Extension of Hospitals and Other Facilities, your committee approves of all the actions reported. Continuation of the work on physician placement programs is especially important, with emphasis placed as it should be on what the community can do to attract new physicians, what the physician contemplating a change can do to adapt himself to a new community, and what organized medicine can do to get these two together and later to maintain the partnership by furnishing postgraduate education and other professional contacts.

Further stimulation of the formation and aggressive functioning of emergency call plans, grievance committees, and other community medical service programs is in order as planned by the Council. Your committee feels that the Council is right in assuming that the report of the Joint Committee on Hospital and Physician Relationships adopted in June, 1953, is supplemental to the report of December, 1951 on "Relationships of Physicians and Hospitals," but believes that it should be emphasized that the later document does not replace or repeal the first report.

It is obvious that the Committee on Indigent Care has given long and thoughtful consideration to that ever-recurring problem. Your reference committee recommends utilization of the "Guides for Evaluating Indigent Medical Care" wherever possible, but agrees with the statement that local problems will at times take precedence.

In the matter of maternal and child care, your committee feels that it cannot improve on the language of the Council report, and therefore quotes its recommendations and suggests your approval: "The only realistic approach to the problems encountered is . . . through local physicians, local hospitals and local agencies working . . . together to provide such care and services as are necessary." The Council recommends to the House of Delegates, and your reference committee approves, "That that portion of the report of the Citizens' Advisory Committee on Medical Care for Dependents of Military Personnel that has to do with maternal and child care be opposed, and that the Department of Defense be made aware of the work and conclusions of this Committee."

In regard to the request that the Los Angeles County Medical Association carry out the requests of the Council in the matter of a pilot study in maternal and child care and that the conclusions of this study be recommended to all county medical societies, your reference committee has taken no action, inasmuch as it understands the study is at present stalled for lack of funds.

The matter of medical care for industrial workers would seem to your committee to be a difficult problem in which many undesirable situations could easily arise. Comment before the committee in this regard would apparently justify the committee's apprehension. So far, union health centers, medical care of coal miners in isolated communities under the United Mine Workers' Welfare and Retirement Program, and similar innovations would seem to fit properly into the necessarily expanding care demanded by industrial groups. However, the opportunities for abuse of great sums of money by either management or the profession, possible extension of paternalistic schemes from areas where they might be necessary to larger urban centers where they would compete with existing medical facilities, and the tendency at times to ignore or override such fundamental concepts as free choice of physician are menacing possibilities. Your committee commends the Council for studies already made, in particular the conferences called in the soft coal areas, and recommends further careful study of this problem, keeping constantly in mind that the practice of medicine by groups and organizations under no circumstances frees the practitioner from adherence to the Principles of Medical Ethics, which guide the rest of us in our day-by-day professional contacts.

The Council reports continuing study of the presently unsatisfactory situation as regards professional liability insurance. Your committee recommends that this be continued and in view of the interim report presented by the Council recommends that no action be taken on Resolution No. 31 presented to this House Dec. 1 by Drs. Halley and Unfug, Colorado, which requested an investigation of this problem by the Board of Trustees.

Veterans medical services are referred to in the body of the Council report and again in the supplemental report presented to this House on Dec. 1. Your reference committee is in full agreement with the Council in its statement that the action of the House of Delegates in New York last June clearly stated its policy regarding treatment of non-service-connected disabilities by the Veterans' Administration. Unless and until that policy is changed by action of this House, the only problem remaining is how best to promote and gain support for this concept. Your reference committee feels that grass roots education of the public as outlined by the Council and as started in limited parts of the country is essential and should be expanded. Your committee feels that attention and effort in this regard is at present more urgent than attempts at direct legislative activity. The physician and the veteran are both voters and taxpayers, and certainly their best interests cannot be too far removed from one another. Education along this line is essential, and with it emphasis should be continued

on the basic concept that only in this way can the best of care be furnished as it should be for those veterans with service-connected injuries or illness.

All of us can read with pride the latest figures on the expansion of voluntary prepayment health insurance. There is no need to quote the statistics furnished by the Council, because by the time that any totals can be published they have been exceeded. Nevertheless, certain fields have not yet been adequately covered, and vigilance and further work are essential. Numberless persons, many at state and local levels, share in the credit for the tremendous expansion of voluntary prepayment insurance. An essential part of this growth, however, has been the correlation and coordination furnished by the Council. Your committee commends the Council and recommends further stimulation along these lines, and also recommends adoption of Resolution No. 7, introduced by Dr. Baum for the Oregon State Medical Society.

The thanks of the committee are extended to those who attended the somewhat drawn-out hearings of the committee and the thanks of the chairman to those members of the committee who cooperated in the preparation of this report.

Report of Council on Constitution and Bylaws

Dr. Louis A. Buie, Chairman, presented the following report, and sections A, B, C, D, and E were referred to the Reference Committee on Amendments to the Constitution and Bylaws, and sections F and G to the Reference Committee on Miscellaneous Business.

To the Members of the House of Delegates of the American Medical Association:

A. The Council has considered several resolutions that were referred to it by the House of Delegates and reports as follows on each resolution:

(1) An amendment to Chapter IV, "Disciplinary Action," was offered by Dr. Joseph D. McCarthy, Nebraska, and, after amendment by the Reference Committee on Constitution and Bylaws, was adopted by the House of Delegates. This proposed amendment as adopted was referred to the Council on Constitution and Bylaws for implementation. The Council, in accordance with the action of the House of Delegates, has divided Chapter IV into 2 sections—Section 1 consisting of the present Chapter IV, and a new Section 2 which reads, "The Judicial Council, after due notice and hearing, may censure, suspend or expel any Service, Affiliate or Honorary Member of the Association for an infraction of the Constitution or these Bylaws, or for a violation of the Principles of Medical Ethics." In addition the Council has added titles to Sections 1 and 2, which read "Active and Associate Members" and "Service, Affiliate, and Honorary Members" respectively.

(2) A resolution on Seating of American Medical Association Delegates was introduced by Dr. John P. Culpepper Jr., Mississippi. This resolution sets forth provisions for the seating or unseating of delegates of constituent associations whose delegate representation was increased or decreaed by virtue of a change in American Medical Association membership within that constituent association. The reference committee, after consideration of the resolution, reported that "because of the different conditions in the several states and because the committee is of the opinion that each state should decide the manner of election of its delegates, this resolution should be referred to the Council on Constitution and Bylaws without recommendation." The Council, after study of this resolution, reached the same conclusion as the reference committee. Each constituent association should determine the method of selection of its delegates in a manner that does not conflict with the provisions of the Constitution and Bylaws of the American Medical Association. The Council, therefore, recommends that the resolution be not adopted.

(3) Dr. Russel V. Lee, Section on Military Medicine, presented the following Resolution on Revision of Principles of Medical Ethics:

Resolved, To substitute for Chapter 1, Sections 1 and 2 of the Principles of Medical Ethics the following section 1:

We, physicians, affiliated with the American Medical Association, recognizing that, in common with physicians of the entire world, we are only trustees for the benefit of all mankind of the great treasure of medical knowledge and skill accumulated through the ages, accept with the trusteeship certain obligations as follows: (1) To make these benefits accessible to all who need them insofar as facilities permit; (2) to exercise these skills for the benefit of all humanity; (3) to strive constantly to improve ourselves in knowledge and skill; (4) to teach our art to all of good character who have the desire and capacity to learn insofar as proper means can be developed; (5) to increase by research and other means this share of knowledge and to make our discoveries freely available to all physicians; (6) to resist all attempts to misuse our services for political purposes, while freely discharging all our obligations as citizens; (7) to devote our skills to the alleviation of suffering and the deferment of death and never for any reason to the termination of human life; (8) to aid and support our medical colleagues in all countries in the attainment of proper humanitarian objectives; (9) to maintain in our relationships with our patients, our colleagues, and the public the strictest standard of personal honor, and (10) to dedicate our knowledge and skills and our lives to the alleviation of suffering, the prolongation of life, and the enrichment of living for all men without thought of any personal advantage or gain.

The reference committee recommended referral of the resolution to the Council on Constitution and Bylaws for its consideration in the forthcoming revision of the Principles of Medical Ethics. The Council has carefully considered this proposed amendment of the Principles of Medical Ethics but has deferred final action pending the consideration of amendments to other sections of the Principles of Medical Ethics which, in the opinion of the Council, are more urgent at this time. The Council, in its revision of the Principles of Medical Ethics, has adopted the policy of proceeding slowly and of giving its attention to those sections which have been most controversial and to the format of the Principles. The revisions suggested by the Lee resolution do not constitute any fundamental change in the existing Principles but are primarily a rewording and restatement of Sections 1 and 2. When the Council has completed other portions of the Principles, it will give further consideration to this resolution. The Council, therefore, recommends that action on the resolution be postponed.

(4) Two resolutions on (*a*) Principles of Medical Ethics, and (*b*) Clarification of Section 5 of Principles of Medical Ethics were introduced by Drs. Harlan English, Illinois, and Millard D. Hill, North Carolina, respectively. These resolutions refer to one of the most controversial sections of the Principles and request the Council on Constitution and Bylaws to outline in specific terms billing procedures when two or more physicians render medical service to a single patient.

After exhaustive consideration of the problem, the Council recommends to the House of Delegates that revision of Section 5, Article VI, Chapter III, be deferred until the constituent associations have had an opportunity to study a questionnaire and report to the Council the billing procedures that are approved in their respective areas. The Council believes that the nature of this subject is so vital that any action taken by this House of Delegates should clearly reflect the prevailing opinions of the constituent associations. The Council proposes to conduct a questionnaire survey of the constituent associations to determine their official policies on this matter, after which it will report its findings to the House of Delegates. The Council recommends that the House endorse its decision to postpone action until this survey has been completed. It also requests that the House urge the constituent associations to give their special attention to this survey.

(5) Resolutions on Membership in the American Medical Association Sections were introduced by Dr. R. J. Azzari, New York, as follows:

Resolved, That the method of enrolling as members of the several sections be altered so that a member will indicate his specialty membership preference at the time of paying his American Medical Association dues, instead of being required, as at present, to be present at the annual meeting; and be it further

Resolved, That the Secretary of the American Medical Association cause to be prepared rosters showing the names of those who have indicated their desire to become members of the several sections, and these lists so prepared shall constitute the membership rolls of the several sections so long as these members remain in good standing.

The reference committee, in conference with the Secretary of the Association, approved the resolution, and it was adopted by the House of Delegates. It was referred to the Council on Constitution and Bylaws for implementation, since it requires an amendment of the Bylaws, Division Two, Chapter V, Sec. 1 (A). The Council recommends that this resolution be reconsidered by the House of Delegates, since it was introduced as a simple resolution and should have been introduced as a resolution to amend the Bylaws, and, furthermore, the implica-

tions of the resolutions are so far-reaching that the Reference Committee on Amendments to the Constitution and Bylaws of this House of Delegates should be given an opportunity to reevaluate their impact with the assistance of the Secretary and members of this Council. It is the opinion of the Council on Constitution and Bylaws that the American Medical Association is divided into sections mainly for the purpose of providing registration at the Scientific Assembly and not to establish autonomous professional societies within the Association.

B. The recommendation has been made to the Council on Constitution and Bylaws by the Secretary and General Manager and the Speaker of the House of Delegates that the Reference Committees on Hygiene and Public Health and Industrial Health be combined, since the number of resolutions referred to each reference committee rarely is sufficient in number to warrant a separate committee and since the subject matter overlaps to a certain extent. The Council concurs in this recommendation and recommends that Chapter XII, Section 4 of the Bylaws be amended as follows to provide this change.

(1) Subsection (F), Section 4, Chapter XII, revise this subsection to read, "(F) Hygiene and Public Health and Industrial Health to which shall be referred all matters relating to hygiene and public health and all matters relating to workmen's compensation and those phases of medical care, including rehabilitation and public health administration, which affect the worker";

(2) Subsection (J), Section 4, Chapter XII, delete the entire subsection.

(3) Subsection (K), Section 4, Chapter XII, shall become Subsection (J) without any change.

(4) Subsection (L), Section 4, Chapter XII, shall become Subsection (K) without any change.

(5) Subsection (M), Section 4, Chapter XII, shall become Subsection (L) without any change.

(6) Subsection (N), Section 4, Chapter XII, shall become Subsection (M) without any change.

C. The Director of the Department of Records and Circulation recommended to the Council that the Bylaws be amended by adding to Chapter III, Section 5, the sentence, "Members of the American Medical Association who have been dropped from the membership roll for nonpayment of annual dues can not be reinstated until such indebtedness has been discharged, but such indebtedness shall apply only to the one year of delinquency." The Council concurs in this recommendation and recommends that the amendment be adopted by the House of Delegates.

D. Review of Sections 1 and 2, Chapter VIII of the Bylaws, reveals that the term "Editor of The Journal" appears in several places. The Council recommends that for the sake of clarity the word "Editor" be used, and that the words "of The Journal" be deleted from the 7th line of Section 1, Chapter VIII, and from the last line of Section 2, Chapter VIII.

E. The Council wishes to call the attention of the House of Delegates to an excellent article entitled "Development of Uniformity in Membership Regulations Between Constituent Associations and the A. M. A." which appeared in the Nov. 28, 1953, issue of THE JOURNAL. The Council believes that every constituent and component medical society should give this article special attention and attempt to implement the recommendations made therein so that membership requirements in the component societies can be made more uniform.

F. Principles of Medical Ethics: The Council recommends that the format of the Principles be changed so that a consistent terminology is used throughout in identifying the various chapters, sections, and paragraphs. To accomplish this uniform identification, the Council recommends the following changes:

(A) 1. All chapters shall be designated by Roman numerals.
2. All sections shall be designated by Arabic numerals.

(B) 1. Delete the designation "Article I" so that the four sections of this article compose the entire Chapter III.
2. Delete "Article II" and substitute "Chapter IV", so that this chapter will contain three sections.
3. Delete "Article III" and substitute "Chapter V," which will contain eight sections.
4. Delete "Article IV" and substitute "Chapter VI" and delete "Article V," which becomes Section 9 of Chapter VI.
5. Delete "Article VI" and substitute "Chapter VII," which contains six sections.

(C) 1. Delete "Chapter IV" and substitute "Chapter VIII," which contains three sections.

The changes enumerated under (B) 1 to 5, provide for the elimination of the word "Article" from the Principles of Medical Ethics and the substitution of the word "Chapter" so that the Principles, after these changes are made, will contain chapters and sections throughout.

G. The Council has given special attention to Section 5, "Educational Information Not Advertising." It recommends that the second paragraph, which refers to advertising, be transferred to Section 4, where it becomes the second paragraph. The Council recommends that the title of Section 5 be changed from "Educational Information Not Advertising" to "The Relationship of the Physician to Media of Public Information," and that the following revised Chapter I, Section 5 by approved by the House of Delegates:

THE RELATIONSHIP OF THE PHYSICIAN TO MEDIA OF PUBLIC INFORMATION

Many people, literate and well educated, do not possess a special knowledge of medicine. Medical books and journals are not always easily accessible or readily understandable.

The medical profession considers it ethical for a physician to meet the request of a component or constituent medical society to write, act or speak for general readers or audiences. On the other hand, it may often happen that the representatives of popular news media are the first to perceive the adaptability of medical material for presentation to the public. In such a situation the physician may be asked to release to the public some information, exhibit, drawing or photograph. Refusal to release this material may be considered a refusal to perform a public service, yet compliance may bring the charge of self-seeking or solicitation.

An ethical physician may provide appropriate information regarding important medical and public health matters which have been discussed during open medical meetings or in technical papers which have been published, and he may reveal information regarding a patient's physical condition if the patient gives his permission, but he should seek the guidance of appropriate officials and designated spokesmen of component or constituent medical societies. Spokesmen should be empowered to give prompt and authoritative replies and a list should be issued which identifies them and discloses the manner in which they may be reached. These provisions are made with full knowledge that the primary responsibility of the physician is the welfare of his patient but proper observation of these ethical provisions by the physician concerned should protect him from any charge of self-aggrandizement.

Scientific articles written concerning hospitals, clinics or laboratories which portray clinical facts and technics and which display appropriate illustrations may well have the commendable effect of inspiring public confidence in the procedure described. Articles should be prepared authoritatively and should utilize information supplied by the physician or physicians in charge with the sanction of appropriate associates.

When any sort of medical information is released to the public, the promise of radical cures or boasting of cures or of extraordinary skill or success is unethical.

An institution may use means, approved by the medical profession in its own locality, to inform the public of its address and the special class, if any, of patients accommodated.

Report of Reference Committee on Amendments to the Constitution and Bylaws

Dr. William L. Benedict, Chairman, submitted the following report, which was adopted and the Resolutions on Membership in American Medical Association Sections, referred to in paragraph A(5) of the report of the Council on Constitution and Bylaws, rescinded:

Your committee has carefully considered the report of the Council on Constitution and Bylaws presented by the Chairman, Dr. L. A. Buie. In reference to A(1) of this report your committee approves the action of the Council relative to Chapter IV of the Bylaws entitled "Disciplinary Action" and recommends adoption of this portion of the report.

A(2) A resolution on seating of American Medical Association Delegates was introduced in June, 1953, by Dr. John P. Culpepper Jr. of Mississippi. Your committee approves the recommendation of the Council that the resolution be not adopted.

A(3) A resolution introduced by Dr. Russel V. Lee proposed specific amendments to the Principles of Medical Ethics. This committee approves the action of the Council in recommending that action on the resolution be postponed.

A(4) The Council recommends that the House endorse its decision to postpone action on these resolutions until a survey of the constituent associations be completed and requests that the House urge the constituent associations to give their special attention to this survey. Your committee commends the Council on its decision and recommends the adoption of this portion of their report.

A(5) This resolution adopted by the House of Delegates in June, 1953, was referred to the Council on Constitution and Bylaws for implementation, since it requires an amendment of the Bylaws, Division Two, Chapter V, Sec. 1(A). Your committee has information that the objectives of the sponsors of this resolution adopted by the House in June, 1953, have been attained by other means. Your committee concurs in the request of the Council that this resolution be reconsidered by the House of Delegates.

(B) Your committee concurs in the recommendation of the Council with the substitution of a comma for "and" after "Hygiene."

(C) Your committee approves the recommendation of the Council on the proposed amendment with the addition to the recommended sentence of the words, "provided that the year 1950 shall not constitute the year of indebtness," so that this amendment will read: "Members of the American Medical Association who have been dropped from the membership roll for nonpayment of annual dues cannot be reinstated until such indebtedness has been discharged, but such indebtedness shall apply only to the one year of delinquency, provided that the year 1950 shall not constitute a year of indebtedness."

(D) This committee approves and recommends the adoption of Section D of the report.

(E) Your committee approves and recommends the adoption of Section E of the report.

Your reference committee desires to express its heartiest commendation to the council on Constitution and Bylaws for its outstanding service to the Association, and to the members of the Council individually and collectively our sincere appreciation of their accomplishments, and to pledge our support to their efforts to so construct the Constitution and Bylaws that they may best guide our members in the conduct of their professional lives.

Report of Reference Committee on Miscellaneous Business

Dr. H. Gordon MacLean, Chairman, submitted the following report, which was adopted:

Report of the Council on Constitution and Bylaws: The Reference Committee on Miscellaneous Business received sections F and G of the report of the Council on Constitution and Bylaws for its consideration. In section F the Council recommends that the format of the Principles of Medical Ethics be changed so that a consistent terminology is used throughout in identifying the various chapters, sections, and paragraphs. The recommendations to accomplish this are approved. In Section G the Council recommends that the title of Section 5 be changed from "Educational Information Not Advertising" to "The Relationship of the Physician to Media of Public Information," and that Section 5 be revised as submitted in the report. Your committee approves these recommendations and recommends the approval of these sections of the report.

Report of the Committee on Blood

Dr. L. W. Larson, Chairman, presented the following report, which was referred to the Reference Committee on Miscellaneous Business:

Defense Blood Requirements: The end of the Korean hostilities resulted in a sharp downward drop in defense blood requirements. Since June 30, 1953, on advice of the Office of Defense Mobilization, the American National Red Cross has closed all of its 15 defense centers and terminated contracts with all of the 33 participating private blood banks which supplied blood for defense use. At present, defense blood collections are made only in regions served by the 45 regional Red Cross centers. The community blood banks have been required to make onerous reorganizations of their personnel and programs as a result of the cancellation of their defense contracts. A public relations problem also has been created since the public and the profession experience difficulty in understanding the continued public appeals for defense blood in the face of the withdrawal of organized defense collections in many areas of the country. It is hoped that the geographic inequities presently existent in the defense collection of blood may be averted by future agreements so that donors in all parts of the country may have the privilege of aiding the defense effort. In recognition of the public relations problem, the Office of Defense Mobilization has invited representatives of the American Medical Association and the American Association of Blood Banks to membership on its publicity policy committee.

Gamma Globulin: In the June report of the Committee on Blood, the composition of the national pool of gamma globulin and its method of allocation and distribution under the Office of Defense Mobilization was described. The actual task of distribution was delegated to the Division of Civilian Health Requirements of the United States Public Health Service. It will be recalled that the plan contemplated distribution of three allocations of poliomyelitis immune globulin. The basic allotment was made available on May 15 on request of state or territorial health officers.

On the basis of an increased incidence of poliomyelitis, 23 areas requested and received additional allocations, and in 14 areas supplementary gamma globulin was made available for mass prophylaxis. Thus from May 15 to Sept. 30, 1953, 1,715,000 cc. of gamma globulin was distributed under basic allocation; 436,344 cc. was made available as an additional allocation; 1,588,930 cc. was utilized in mass prophylaxis; and 32,402 cc. was used for research and special allocations. Of the total of 3,772,676 cc. thus distributed, 1,207,600 cc. was supplied to the pool by the National Foundation for Infantile Paralysis. The remaining 2,565,076 cc. was supplied by the American National Red Cross. In July, the Surgeon General of the United States Public Health Service organized a committee of practicing physicians to advise the service on practical problems encountered by practicing physicians in the explanation and the operation of the distribution system. Taken from the over-all viewpoint, the plan seems to have operated fairly smoothly. Initially, there were occasional difficulties in securing gamma globulin for measles prophylaxis. This resulted from misunderstanding on the part of a few local health officers that measles and infectious hepatitis should be given priority of use of gamma globulin.

If the incidence of poliomyelitis continues on the same level as indicated for the period May 15 to Sept. 30, 1953, it is anticipated that the pool will have a surplus of gamma globulin to carry over for use in the year 1954.

Progress Report on National Blood Program: The House of Delegates in the June, 1953, session adopted a Resolution on Blood Banking which urged "the establishment of a coordinated national blood bank program organized by the American Medical Association, the American National Red Cross and other qualified organizations interested in blood banking in so far as may be appropriate. . . ." The House also approved a request of the Committee on Blood that the committee be authorized to take part in conferences on a national blood program with the interested agencies.

Pursuant to these instructions, four meetings were arranged. The first, on July 25, 1953, in Chicago with representatives from the American National Red Cross, developed broad general areas of agreement on the necessity for a coordinated national blood program and an agreement that other professional organizations should be included in further conversations.

At the second meeting, in Washington on Sept. 9, the American Hospital Association, the American Association of Blood Banks, and the American Society of Clinical Pathologists were invited to attend. Each organization was represented by two appointees and the American National Red Cross and the American Medical Association by four appointees, with the chairman of the Committee on Blood presiding.

Representatives of all the organizations present expressed the belief that a voluntary national organization with representation from all agencies interested in blood collection, preservation, and distribution was desirable. In order to present some concrete recommendations to each organization's policy making bodies, the representatives at this meeting requested the chairman to appoint a steering committee of five members representing all the organizations present for the purpose of formulating a general plan of organization on the following basis: (1) to coordinate activities of member groups; (2) to recommend pertinent policy to constituent members on the national level; and (3) to explore further fields of activity into which the program should advisedly enter.

The steering committee was instructed to have this plan of organization ready for presentation to the joint committee on Nov. 13, in Washington. The steering committee met in Chicago on Oct. 21, and devised an organizational plan which was further discussed and amended by the representatives of the aforementioned agencies in the Nov. 13 meeting. As none of the representatives could pledge their organization's support of the plan, it was agreed that the plan should be submitted to each organization's policy making bodies for ratification, modification, or rejection. A copy of the plan of organization of the National Blood Foundation has been distributed to each member of the House of Delegates for purposes of information.

The board of governors of the American National Red Cross on Nov. 16, 1953, adopted the following resolution after considering the contemplated plan of organization of the National Blood Foundation:

That the Board of Governors approve in principle the formation of an organization comprised of representatives from agencies interested in activities related to the collection, processing, and use of blood and its derivatives, with the understanding that the purpose of this organization shall be to establish a national blood program with a principal objective of assuring an adequate supply of blood and blood derivatives for civilian and military use in time of peace and for emergency without charge for the product itself. It is further recommended that the president or his designee be authorized to commit funds of the Red Cross on a cooperative basis with the American Medical Association and to the extent necessary during the next three years to effect and sustain such an organization and that the staff be directed to continue to plan with the other interested agencies with a view toward the development of a comprehensive plan to be submitted to the Board of Governors for subsequent action.

Since the plan of organization of the National Blood Foundation requires the assumption of certain financial obligations on the part of the American Medical Association, the Committee on Blood has presented the plan to the Board of Trustees for its consideration and for its recommendations to the House of Delegates.

Supplementary Report of Board of Trustees

Dr. L. W. Larson, Trustee, presented the following supplementary report, which also was referred to the Reference Committee on Miscellaneous Business:

O. Progress Report on the National Blood Program

In reviewing the plan of organization of the proposed National Blood Foundation, referred to the Board of Trustees by the Committee on Blood, the Board felt that approval in principle of the establishment of a national blood program has already been achieved by approval of the Resolution on Blood Banking at the June, 1953, meeting of the House of Delegates.

The Board of Trustees has not had complete opportunity to evaluate the financial and legal obligations to be assumed by the American Medical Association in the proposed organization. For the reasons stated, the Board of Trustees recommends that the Committee on Blood be instructed to continue its efforts, in cooperation with the other interested agencies, toward the development of an organization which will command the endorsement and support of the agencies concerned and incorporate the sound principles already enunciated by the House of Delegates.

Report of Reference Committee on Miscellaneous Business

Dr. H. Gordon MacLean, Chairman, submitted the following report, which was adopted.

Report of Committee on Blood and Supplementary Report of Board of Trustees on the Progress Report on the National Blood Program: Your committee reviewed with interest the report of the Committee on Blood and viewed with satisfaction its continued attempts to develop a comprehensive plan on a nationwide basis. In the supplementary report concerning the organization of the proposed "National Blood Foundation," the Board of Trustees felt that approval in principle of the establishment of a national blood program has already been achieved by the approval of the Resolution on Blood Banking at the June, 1953, meeting of the House of Delegates, which reverts to the Ludwig resolution. The Board of Trustees stated in this report that it had not had complete opportunity to evaluate the financial and legal obligations to be assumed by the American Medical Association in the proposed organization. For the reasons stated, the Board of Trustees recommended that the Committee on Blood be instructed to continue its efforts, in cooperation with other interested agencies, toward the development of an organization which will command the endorsement and support of the agencies concerned and incorporate the sound principles already enunciated by the House of Delegates.

Your committee approves the report of the Committee on Blood and the recommendations of the Board of Trustees in its supplementary report.

Introduction of Secretary of Southern Medical Association Mr. C. P. Loranz

The Speaker introduced to the House of Delegates Mr. C. P. Loranz, Secretary of the Southern Medical Association for more than 40 years.

New Business

The Speaker announced a new procedure for the presentation of resolutions, as follows:

Instead of having a roll call by states, as we have had in the past for the introduction of resolutions, in order to make your work easier, the resolutions have been numbered. You will notice that in the supplementary reports of the Board of Trustees letters were used. The resolutions are designated by number. I am going to ask the introducers of resolutions please to keep track of the numbers, and I am going to ask Nos. 1, 2, 3, 4, and 5 to come up here and sit at the table. No. 1 will be the first to be called, and, as each man moves up, another one will come up, so that we shall keep these five chairs filled at all times. If you have a resolution to be introduced, you will know when you are going to be called by the number that is on your resolution.

No. 1. Resolutions on Ethical Advertising

Dr. Frank J. Holroyd, West Virginia, presented the following resolutions, which were referred to the Reference Committee on Hygiene and Public Health:

The following resolution was unanimously adopted by the House of Delegates of the West Virginia State Medical Association at the second session held at the Greenbrier, White Sulphur Springs, July 24, 1953:

Whereas, The advertising of therapeutic agents in the official journals of the American Medical Association and the promotion of Council-approved medications by this and all other means are of incalculable importance in influencing their use by medical practitioners; and

Whereas, The advertising in many other journals, national and state, takes its tone from the official journals of the American Medical Association; and

Whereas, Claims as to therapeutic advantages and disadvantages can be so devised as to give a total impression different from that which is justified; therefore be it

Resolved, That the West Virginia State Medical Association urges the House of Delegates and the Board of Trustees of the American Medical Association to give consideration to measures which will insure complete conformity of all therapeutic claims with those recognized by the appropriate official authorities of the American Medical Association, and further, that steps be taken to strengthen the facilities for the detection and evaluation of all toxic reactions to therapeutic agents; and be it further

Resolved, That the delegates of the West Virginia State Medical Association are hereby instructed to introduce this resolution to the House of Delegates at the Clinical Meeting in St. Louis in December, 1953.

Report of Reference Committee on Hygiene and Public Health

The Reference Committee on Hygiene and Public Health included its action with respect to the foregoing Resolutions on Ethical Advertising in its report on Supplementary Report

of the Board of Trustees G. This will be found on page 1539 of this issue of THE JOURNAL.

No. 2. Resolutions on Principles of Medical Ethics

Dr. George Braunlich, Iowa, introduced the following resolutions which were referred to the Reference Committee on Miscellaneous Business:

WHEREAS, The prime objective of the medical profession is to render service to humanity, with reward or financial gain a subordinate consideration; yet

WHEREAS, The matter of fees, collections, and statements must be covered; and

WHEREAS, The decision as to the ethical or unethical nature of practice must be based on the ultimate effect for good or ill on the patient as an individual and the public as a whole; and

WHEREAS, With the increasing development of medical knowledge and the increasing specialization of medical skill, it has become more and more frequently necessary for two or more physicians to participate in the care of a patient; and

WHEREAS, It is also a known fact that for the welfare of the patient, two or more doctors must be present at surgery in the event of the disability of any one of them during the operation or in an emergency, and this is a requirement in many hospitals' rules and regulations; and

WHEREAS, In many communities in Iowa, it has been common practice for the general practitioner or family physician and/or another physician to participate in the medical and surgical care of the patient, the family or patient in many instances requesting the family physician to be present at surgery and to assist in the care of the patient; and

WHEREAS, It has been accepted and approved by the community as a community practice conveying definite benefits to the community, and the procedure has received community approval as being in the best interest of the patient; and

WHEREAS, The above practice is generally recognized throughout the State of Iowa in both large and small communities; and

WHEREAS, The patients and the public have accepted and approved the joint activities of doctors of medicine on individual cases, in cases involving surgery, or in cases involving diagnosis and treatment only, all to the benefit of the patient; and

WHEREAS, In many communities there have been joint activities by doctors of medicine and one bill rendered therefor with the consent of the patient; and

WHEREAS, Physicians and surgeons have, in their activities of rendering joint services to the patient with the patient's consent, collected the fee on one statement and have thereby fulfilled their plain and palpable duty to their fellow men and have had due regard to all of the circumstances of each particular situation and relations; and

WHEREAS, In many instances patients have expressed their own desire for one bill, the payment of the bill at one place, and so by custom made the practice an accepted one in many communities; and

WHEREAS, Public policy is the community common sense and common conscience extended and applied throughout the state to matters of public morals, public health, public safety, public welfare, and the like; now therefore be it

Resolved, That when two or more doctors actually and in person render service to one patient, each physician may, if he so desires, render to the patient an individual bill for his individual services or the doctors may submit one statement to the patient for the services rendered, and it should be made clear to the patient or his legal representative that this fee is to be divided in proportion to the services rendered, and the statement shall show the names of the doctors and respective amounts to be paid each doctor. The patient's consent, either expressed or implied, should be obtained. The fees may be paid in their entirety to either physician by the patient, and the one receiving payment shall forward the other his fee. Under no circumstances shall it be considered ethical for doctors to submit joint bills unless both have actually rendered service. Division of fees for referrals only shall be considered unethical; and be it further

Resolved, That in legal partnerships of doctors, or clinics of doctors, or where doctors have joined together in the practice of medicine, and so hold themselves out to the public and patients, where all income and expenses are a joint account or joint venture, it is ethical and legal for the members of the group to confer and care for a patient and to render one bill to the patient, and the income shall be divided in accordance with their contract basis or salary or percentage arrangement.

Report of Reference Committee on Miscellaneous Business

Dr. H. Gordon MacLean, Chairman, presented the following report, which was adopted:

Resolution No. 2 on the Principles of Medical Ethics: Those resolutions were passed by the house of delegates of the Iowa State Medical Society in June, 1953. After thorough discussion of the problems involved concerning the billing of patients, your committee feels that it is unable to render a decision because the final interpretation of ethics is within the province of the Judicial Council. We note in the minutes of the House of Delegates at its December, 1952, meeting in Denver that the Judicial Council rendered an opinion on an almost identical question. On page 1706 of THE JOURNAL in the Dec. 27, 1952, issue is found this statement: "That when a surgeon renders his bill for his fee, it should not include bills from colleagues who act as assistants or anesthetists, but these colleagues should render their own bills."

Your committee recommends that these resolutions be referred to the Judicial Council requesting that the Council investigate the factors involved in the matters as presented and determine if there are new factors or new facets that would cause it to change the opinion of 1952 quoted above. In addition we recommend that the Judicial Council be specifically requested to report on this request at the June 1954 annual meeting. We further recommend that this action be approved by the House of Delegates.

No. 3. Resolution on Chiropractic and Naturopathic Education

Dr. J. Paul Jones, Alabama, introduced the following resolution, which was referred to the Reference Committee on Hygiene and Public Health:

WHEREAS, The medical profession is morally, and in some instances legally, obligated to protect the public against irregular practitioners of all types; and

WHEREAS, Chiropractors and naturopaths are constantly trying to cloak themselves with unwarranted status by means of legislative action; and

WHEREAS, Although we know the basic tenets of both chiropractic and naturopathy to be without scientific basis, the argument most readily understandable to a legislator seems to lie within the lack of proper training received in chiropractic or naturopathic schools; and

WHEREAS, When appearing before a legislative committee for the purpose of a hearing, we do not have and therefore cannot use concrete evidence regarding the quality of training received in either chiropractic or naturopathic schools; and

WHEREAS, This situation resolves itself into the word of one group against that of another, which in turn makes our strongest point—the lack of proper training—the weakest link in our argument; therefore be it

Resolved, That the American Medical Association, through its proper council, institute means and procure accurate and concrete evidence on the quantity and quality of training received in chiropractic and naturopathic schools; and be it further

Resolved, That the American Medical Association make this information available to the constituent state associations not later than Jan. 1, 1955.

Report of Reference Committee on Hygiene and Public Health

Dr. Thurman B. Givan, New York, Chairman, presented the following report, which was adopted:

Res. No. 3 on Chiropractic and Naturopathic Education: Your committee approves this resolution and recommends that the American Medical Association, through its Board of Trustees, by means of a proper council or an outside agency, institute methods and procure accurate and concrete evidence on the quantity and quality of training received in chiropractic and naturopathic schools, and it is further recommended that the American Medical Association make this information available to the constituent state associations at the earliest possible date.

No. 4. Resolution on Use of Term Rehabilitation

Dr. Edward L. Compere, Section on Orthopedic Surgery, introduced the following resolutions, Nos. 4, 5, 6, and 6-A, all of which were referred to the Reference Committee on Sections and Section Work:

WHEREAS, Rehabilitation is the concern not alone of one group of physicians but rather the concern of physicians in every branch of medicine, the present tendency for one group of physicians to arrogate the term "rehabilitation" unto themselves cannot be justified; and

WHEREAS, Orthopedic surgery is particularly concerned with this matter and from its inception as a specialty has always had the rehabilitation of the physically disabled as one of its primary activities and has contributed and is contributing much to the development of this field; and

WHEREAS, The term "rehabilitation" has been appended to the title of one of the official councils, the council designated as the Council on Physical Medicine and Rehabilitation; to one of the scientific sections, the Section on Physical Medicine and Rehabilitation; and to a specialty board, the American Board of Physical Medicine and Rehabilitation; and

WHEREAS, It is our firm belief and conviction that such use of this term is inappropriate and misleading and causes confusion in the minds of the medical profession and the public at large; therefore be it

Resolved, That the House of Delegates advise the Council on Physical Medicine and Rehabilitation, the Section on Physical Medicine and Rehabilitation, and the American Board of Physical Medicine and Rehabilitation that it would be desirable and appropriate to discontinue the use of the term "rehabilitation" in the title.

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195

No. 5. Resolution on Advisory Committee to Council on Medical Education and Hospitals

WHEREAS, We believe that it is inappropriate for a subcommittee from the Council on Physical Medicine and Rehabilitation to serve in an advisory capacity to the Council on Medical Education and Hospitals regarding the educational standards of schools of physical therapy and occupational therapy, because the training of these technicians involves the services of many other fields of medicine, and advisory committees should consist of a much broader group; and

WHEREAS, Physical therapy and occupational therapy were developed with the encouragement and under the auspices of orthopedic surgery; and

WHEREAS, The education of physical therapy technicians and occupational therapists from the beginning was guided by orthopedic surgeons; and

WHEREAS, It is only proper that orthopedic surgery should continue as a participant in maintaining the standards of education and the rules of activity of physical therapy and occupational therapy; therefore be it

Resolved, That this advisory committee to the Council on Medical Education and Hospitals be selected from nominees submitted by the executive committees of the Sections on Physical Medicine, Orthopedic Surgery, Nervous and Mental Diseases, General Practice, and other sections which are concerned with the question of the training and education of lay technicians.

No. 6. Resolution on Change in Name of Council on Physical Medicine and Rehabilitation

WHEREAS, We do unanimously hold that it is not advisable to designate a council which was created for the purpose of evaluating and making recommendations regarding medical equipment and apparatus as the Council on Physical Medicine, with or without the term "Rehabilitation" being appended; therefore be it

Resolved, That the House of Delegates recommend to the Council on Physical Medicine and Rehabilitation that the name be changed to one more appropriate to the duties of that Council.

No. 6-A. Joint Resolutions from the Executive Committees of the Sections on Orthopedic Surgery, and Physical Medicine and Rehabilitation

WHEREAS, Certain resolutions have been introduced in the House of Delegates from the Section on Orthopedic Surgery relative to the deletion of the term "Rehabilitation" from the Board, Section, and Council on Physical Medicine and Rehabilitation; and

WHEREAS, At a meeting of a committee of the Board of Trustees with committees representing the Sections on Orthopedic Surgery, and Physical Medicine and Rehabilitation, and the Council on Medical Education and Hospitals, it was agreed that many basic principles are involved in the above-mentioned resolutions; therefore be it

Resolved, That action on the three resolutions from the Section on Orthopedic Surgery be deferred until the June, 1954, meeting of the House of Delegates of the American Medical Association; and be it further

Resolved, That the Board of Trustees of the American Medical Association be requested to appoint a committee composed of representatives of the various specialties most directly concerned with rehabilitation and, if deemed advisable, representatives of the Board of Trustees, to study the issues which have been raised, and to report to the House of Delegates in June, 1954, with recommendations relative to the following questions:

1. Should the Council on Physical Medicine and Rehabilitation be reorganized and renamed to indicate more clearly a primary function having to do with the investigation, standardization, and certification of medical equipment, apparatus, and materials?

2. Should another council be formed properly representative of the various branches of medicine which are concerned with rehabilitation, such council to be named, "The Council on Rehabilitation"?

3. Should the Section on Physical Medicine and Rehabilitation be renamed the "Section on Physical Medicine"?

4. Should the American Board of Physical Medicine and Rehabilitation be renamed?

Report of Reference Committee on Sections and Section Work

Dr. Jesse D. Hamer, Chairman, presented the following report, which was adopted:

Three resolutions, Nos. 4, 5, and 6, were introduced by Dr. Edward L. Compere, delegate of the Section on Orthopedic Surgery, and were before your committee for its consideration, as well as No. 6-A, a Joint Resolution from the Executive Committee of the Section on Orthopedic Surgery and the Section on Physical Medicine and Rehabilitation, which was introduced conjointly by Dr. Edward L. Compere, Section on Orthopedic Surgery, and Dr. Frank H. Krusen, Section on Physical Medicine and Rehabilitation.

Your reference committee, after due consideration of all the remarks made before it by representatives of these two sections, feels that the adoption by this House of Resolution No. 6-A would be the proper procedure in this instance. It would therefore recommend that Resolutions Nos. 4, 5, and 6 be tabled and that the content of Resolution No. 6-A be adopted.

No. 7. Resolutions on Improvement of Existing Voluntary Prepayment Medical Care Plans

Dr. W. W. Baum, for the Oregon State Medical Society, introduced the following resolutions, which were referred to the Reference Committee on Insurance and Medical Service:

WHEREAS, The American Medical Association and the physicians of the United States have strongly advocated voluntary health insurance; and

WHEREAS, This places on them a responsibility to make every effort to promote such prepaid medical coverage for all citizens whose circumstances make them eligible; and

WHEREAS, There are two large groups of citizens for whom improved coverage could be offered under present prepaid medical care plans, namely: (*a*) those individuals who suffer catastrophic or long-continued and highly expensive illness and whose financial resources are not adequate to meet the cost thereof and (*b*) those citizens who have retired and are living on small incomes and who are not eligible under presently existing public or private plans; and

WHEREAS, The Council on Medical Service of the American Medical Association is charged with the responsibility for investigations and recommendations in the field of prepaid medical care; therefore be it

Resolved, That this House of Delegates commend the Council on Medical Service for the excellent work it has done in this field in the past; and, as evidence of our continued confidence in its ability; be it further

Resolved, That this House of Delegates request the Council on Medical Service to proceed immediately with a special study of the two problems mentioned above and to present its findings and recommendations to the House of Delegates not later than the 1954 Clinical Meeting; and be it further

Resolved, That these findings and recommendations of the Council on Medical Service be published in some convenient form and made available not only to the medical profession but also to nonmedical groups or individuals working in the field of prepaid medical care.

Report of Reference Committee on Insurance and Medical Service

The report of the reference committee on Resolution No. 7 is contained in the next to the last paragraph of the committee's report on the report of the Council on Medical Service on page 1548 of this issue of THE JOURNAL.

No. 8. Resolutions on Dr. Elmer Lee Henderson

Dr. Clark Bailey, for the Kentucky delegation, introduced the following resolutions, which were adopted by a unanimous rising vote, without referral:

WHEREAS, In the passing of Dr. Elmer Lee Henderson of Louisville, Ky., on July 30, 1953, the nation lost one of its most honored citizens, and the people and medical profession of the world suffered an irreparable loss; and

WHEREAS, Dr. Henderson, one of medicine's most astute and effective statesmen, brought dignity, courage, and clear vision to his distinguished service as President of the Jefferson County Medical Society, the Kentucky State Medical Association, The Southern Medical Association, the American Medical Association, the World Medical Association, and the American Medical Education Foundation, as well as to his numerous other civic and professional activities; and

WHEREAS, Dr. Henderson, through his vigorous devotion to the cause of freedom in all phases of American life, provided long and continuous leadership, which immeasurably helped the people reaffirm their dedication to America's principles of liberty; now therefore be it

Resolved, That the House of Delegates of the American Medical Association gratefully acknowledge and affirm its deep appreciation for Dr. Henderson's unsparing work as physician, citizen, and medical leader, and his everlasting gifts to his fellow man; and be it further

Resolved, That the resolution of the House of Delegates of the American Medical Association be made a part of its permanent record and that a copy be sent to Mrs. Laura Henderson of Louisville, Ky., the bereaved widow, assuring her of our most sincere sympathy in the great loss that the entire medical profession all over the nation shares with her.

No. 9. Resolution on Unethical Practices

Dr. John F. Burton, Oklahoma, presented the following resolution, which was referred to the Reference Committee on Miscellaneous Business:

WHEREAS, Published statements of certain medical spokesmen concerning alleged unethical practices by members of the medical profession have tended to destroy the confidence of patients in their physicians, without solving the basic problems involved; and

WHEREAS, The American Medical Association has received requests calling for action to counteract this type of publicity; and

WHEREAS, This House of Delegates recognizes that the members of the American Medical Association look to the association to take steps leading to the elimination of publicity inimical to best physician-patient relationships, and to take steps to assure the highest quality of medical service; and

WHEREAS, This House of Delegates believes it necessary to determine the facts in reference to these published accusations; therefore be it

Resolved, That this House of Delegates direct the Speaker of the House of Delegates to appoint a special committee with broad representation throughout the profession whose function it shall be: (1) To study all aspects of the problems of public relations created by recent adverse publicity; (2) To study the problems of professional interrelationships such as are alleged in this publicity, particularly as they affect the quality and cost of medical care, utilizing whatever techniques are necessary to obtain factual information thereon; and (3) To report findings and submit recommendations for the solution of the above problems to the House of Delegates in June, 1954.

Report of Reference Committee on Miscellaneous Business

Dr. H. Gordon MacLean, Chairman, submitted the following report, which was adopted:

Res. No. 9 on Ethical Practices: This resolution has to do with published statements of certain medical spokesmen concerning alleged unethical practices by members of the medical profession which have tended to destroy the confidence of patients in their physicians without solving the basic problems involved. Your committee recognizes that the members of the American Medical Association look to the Association to take steps leading to the elimination of publicity inimical to the best physician-patient relationships and to take steps to assure the highest of medical service, and that it is also necessary to determine the facts in reference to these published accusations. In consultation with officers of the American Medical Association, your committee was informed that this study is already being undertaken. Your committee approves the intent of this resolution but believes that it would be difficult to implement as suggested in the "Resolved" portion. Therefore, your committee recommends that this resolution be referred to the Board of Trustees for further study and implementation, and directs the Board to appoint a special committee with broad representation throughout the profession to carry out the purposes of the resolution.

No. 10. Resolution on Social Security

Dr. Willard A. Wright, North Dakota, introduced the following resolution, which was referred to the Reference Committee on Legislation and Public Relations:

WHEREAS, Legislation has been introduced into the Congress providing for the extension of compulsory coverage under Title II of the Social Security Act to self-employed persons, including physicians; and

WHEREAS, The House of Delegates has in the past registered its disapproval of the principle involved in this legislation; and

WHEREAS, Physicians desire the continued right to establish retirement benefits for themselves on a voluntary basis rather than being compelled to participate in a tax-supported government program which they do not want; and

WHEREAS, The Jenkins-Keogh bills (H.R. 10 and H.R. 11) now before the Congress provide for development of a voluntary pension program which is equitable, free from compulsion, and satisfies the retirement needs of physicians; therefore be it

Resolved, That this House of Delegates reaffirm its support and endorsement of the voluntary pension program provided in the Jenkins-Keogh bills and its strong opposition to the extension of compulsory coverage of physicians under Title II of the Social Security Act.

Report of Reference Committee on Legislation and Public Relations

The report of the reference committee on Resolution No. 10 is contained in its report on the report of the Committee on Legislation on page 1535 of this issue of THE JOURNAL.

No. 11. Resolution on Improvement of Rural Health

Dr. Willard A. Wright, North Dakota, presented the following resolution, which was referred to the Reference Committee on Insurance and Medical Service:

WHEREAS, Over the last few years the American Medical Association, through its Council on Rural Health and the constituent and component medical societies, has promoted a program designed to improve rural health; and

WHEREAS, This policy has been attended with such success that the medical profession has earned a place of high esteem among America's farm leaders and people; and

WHEREAS, Notwithstanding these successful efforts it is now recognized that there is need for further local support of the rural health program through cooperation among agricultural, medical, civic, and lay groups; therefore be it

Resolved, That this House of Delegates urge the constituent and component medical societies to organize rural health committees composed of personnel with an interest in rural health problems and an understanding of the needs for rural medical care, and to activate a rural health program in their respective communities.

Report of Reference Committee on Insurance and Medical Service

Dr. John M. Porter, Chairman, submitted the following report, which was adopted.

Your Reference Committee on Insurance and Medical Service had referred to it two major propositions, one concerning the work of the Council on Rural Health with one resolution referring to work of that council.

The Report of the Council on Rural Health speaks for itself and should be read by all of us who practice outside the metropolitan or industrial centers. If, because of isolation and sometimes apparently radical thinking, the farmer seems to require more than his share of attention or even subsidization, certainly we must agree that no better friend of medicine or more fundamentally necessary individual exists. In the opinion of your reference committee, the work of the Council on Rural Health, with its emphasis on education and its admirable record of cooperation with farm groups, should be continued and its efforts commended.

No. 12. Resolution on Abolition of Matching Plan for Internships

Dr. Charles L. Farrell, Rhode Island, introduced the following resolution, which was referred to the Reference Committee on Medical Education and Hospitals:

WHEREAS, The "Matching Plan" instituted by the American Medical Association for the apportionment of interns has frequently worked to the detriment of smaller hospitals by depriving them of an adequate allocation of interns; and

WHEREAS, The smaller hospitals must still carry the bulk of patient load and, to do so effectively, must have adequate house staffs; therefore be it

Resolved, By the House of Delegates of the American Medical Association that the "matching" system of intern selection be abolished.

Report of Reference Committee on Medical Education Hospitals

Dr. James Z. Appel, Chairman, submitted the following report, which was adopted:

Your reference committee has received Resolution No. 12 introduced by Dr. Charles L. Farrell, Rhode Island, entitled "Abolition of Matching Plan for Internships." Your reference committee enjoyed long debate by many members of the Association and the comments of the representatives of the Student American Medical Association were very helpful. At no time during the debate was it pointed out how the matching plan *per se* is detrimental to the distribution of interns. Your reference committee, therefore, recommends that this resolution be rejected.

No. 13. Resolution on Listing of Accredited Hospitals

Dr. Charles L. Farrell, Rhode Island, presented the following resolution, which was referred to the Reference Committee on Medical Education and Hospitals:

WHEREAS, The Council on Medical Education and Hospitals has published a list of Approved Internships revised to Sept. 1, 1953, that omits the names and descriptions of hospitals which, though approved, have not subscribed to the Matching Plan, and then lists them supplementary to the general listing; and

WHEREAS, Such listing creates the impression that such hospitals are not of the same caliber or rating as the ones in the general listing; and

WHEREAS, This listing works to the disadvantage of hospitals seeking interns; therefore be it

Resolved, That the House of Delegates of the American Medical Association instruct the Council on Medical Education and Hospitals to revise and republish immediately its listing to include all hospitals accredited for intern training in one master list and to designate by column marking, asterisk or other device, those not subscribing to the Matching Plan.

Report of Reference Committee on Medical Education and Hospitals

Dr. James Z. Appel, Chairman, presented the following report, which was adopted:

Your reference committee received Resolution No. 13 introduced by Dr. Charles L. Farrell, Rhode Island, entitled "Listing of Accredited Hospitals by the Council on Medical Education and Hospitals."

Your reference committee recognizes that for economic reasons the Council has published a separate listing of hospitals that have subscribed to the Matching Plan and that segregation of nonmember hospitals might leave the inquiring intern and the general public to feel that such hospitals are

discriminated against. Therefore, your reference committee wishes to present a substitute resolution as follows:

Resolved, That the House of Delegates of the American Medical Association instruct the Council on Medical Education and Hospitals at the appropriate time to publish a listing of all hospitals accredited for intern training in one master listing and to designate by bold face type or column marking those subscribing to the Matching Plan.

Your reference committee recommends the adoption of this substitute resolution.

No. 14. Resolution on More Equitable Distribution of Interns

Dr. Charles L. Farrell, Rhode Island, introduced the following resolution, which was referred to the Reference Committee on Medical Education and Hospitals:

WHEREAS, Many hospitals have offered internships out of proportion to bed capacity and clinical needs; and

WHEREAS, Many small hospitals accredited for internship are unable to secure sufficient interns and often secure none at all; and

WHEREAS, The only possible solution to this problem is a more equitable distribution of interns among accredited internships; therefore be it

Resolved, That the Council on Medical Education and Hospitals of the American Medical Association be instructed to take immediate steps to evaluate the actual needs of accredited hospitals for intern training and to develop a formula for equitable distribution that will insure interns for the smaller accredited hospitals.

Report of Reference Committee on Medical Education and Hospitals

Dr. James Z. Appel, Chairman, submitted the following report, which was adopted:

Your reference committee received Resolution No. 14 introduced by Dr. Charles L. Farrell, Rhode Island, entitled "More Equitable Distribution of Interns."

At the New York meeting of the House of Delegates in June, 1953, five resolutions on interns were considered by the Reference Committee on Medical Education and Hospitals. One of these resolutions was essentially the same as Resolution No. 14. Your House of Delegates approved a recommendation that a further study be made by a committee appointed by the Speaker of the House of Delegates, at least half of whom are doctors in private practice of medicine not connected with medical schools or affiliated hospitals. Furthermore, the Council on Medical Education and Hospitals has indicated in its report it is most willing and anxious to cooperate with this special committee. Your committee believes this special committee's charge will cover the content of Resolution No. 14 and therefore recommends that no action be taken at this time.

No. 15. Resolutions on Death of Dr. Frank Kells Boland

Dr. Eustace A. Allen, Georgia, introduced the following resolutions, which were adopted by a unanimous rising vote, without referral:

WHEREAS, Frank Kells Boland, a leading figure in the field of surgery for half a century, died Nov. 11. He was nationally known for his research in the history of anesthesia. It was through his efforts that Dr. Crawford W. Long was recognized as the discoverer of ether and anesthesia. He was the author of the book "The First Anesthetic," published in 1950; and

WHEREAS, He was interested in the history of medicine in Georgia and was also author of a book on the subject. He was a past president of the Atlanta Historical Society and was a member of numerous civic and fraternal organizations. He was a great leader in medical and surgical societies, having served as president of county, state, and medical alumni organizations and was also southeastern governor of the American College of Surgeons; and

WHEREAS, In the passing of this great medical leader, teacher of surgery, Georgia, the South, and the nation have lost one of its outstanding citizens. Dr. Boland, until the last, was always ready to serve his patients and all who called upon him for help. He never turned down a patient's call, and it is truly said that the spirit of service self-exemplified the man whose death will be mourned by all who knew him; therefore be it

Resolved, That the House of Delegates of the American Medical Association wishes to express its feeling of an irreplaceable loss in the death of Dr. Frank Kells Boland on Nov. 11, 1953; and be it further

Resolved, That a copy of these resolutions be forwarded to the family of our deceased friend.

No. 16. Resolution on Commission on Intergovernmental Relations

Dr. Vincent W. Archer, Virginia, introduced the following resolution, which was referred to the Reference Committee on Miscellaneous Business:

WHEREAS, The President of the United States, under authority of the Congress, has appointed a Commission on Intergovernmental Relations, now known as the Manion Commission; and

WHEREAS, This commission has been charged with the responsibility of making inquiry into federal-state relations in reference to grants-in-aid and appropriations to states on a matching basis; and

WHEREAS, This inquiry will be concerned with the present status of such appropriations, the present and possible future needs and administrative set-ups as they now exist or should exist; therefore be it

Resolved, That the administrative body of each state and territorial medical society take immediate steps to contact the chairman of the commission in order to determine in what way the state society and appropriate state agencies can cooperate with the commission in aiding in the accomplishment of its purpose.

Report of Reference Committee on Miscellaneous Business

Dr. H. Gordon MacLean, Chairman, presented the following report, which was adopted:

Res. No. 16 on Commission on Intergovernmental Relations: Your committee approves the resolution that the administrative body of each state and territorial medical association take immediate steps to contact the chairman of the commission in order to determine in what way the state medical society and appropriate state agencies can cooperate with the Commission in aiding in the accomplishment of its purpose.

No. 17. Resolution on Veterans Care and Medical Training

Dr. John F. Burton, Oklahoma, introduced the following resolution, which was referred to the Reference Committee on Medical Education and Hospitals:

WHEREAS, There is a variance of opinion regarding the requirements of the bed ratio to student personnel for an approved school of medicine; and

WHEREAS, There are differences of opinion in regard to the question of rendering medical care and bedside teaching of medicine; therefore be it

Resolved, That the American Medical Association Board of Trustees, acting through the Council on Medical Education and Hospitals, initiate plans to solve these differences by: (1) establishing a bed ratio per student based upon the student personnel of the last two years of medicine, and (2) acting through the deans' committees, regulate medical attention rendered to veterans in Veterans Administration hospitals for teaching purposes by limiting to those cases of service-connected origin only.

Report of Reference Committee on Medical Education and Hospitals

Dr. James Z. Appel, Chairman, presented the following report, which was adopted:

Your reference committee received Resolution No. 17, introduced by John F. Burton, Oklahoma, entitled "Veterans Care and Medical Training."

It was pointed out to your reference committee that the teaching load ratio is a better method of measuring the number of patients per student than a bed ratio per student as advocated in this resolution. Your reference committee recommends that this portion of the resolution be rejected.

Your reference committee is in agreement with the American Medical Association policy that veterans care should be limited to those of service-connected origin with the exception of some specific cases. Your reference committee is also cognizant that it is the duty of physicians to render medical care whenever needed, and, so long as it is law and the administrative policy of the Veterans Administration to function along this line, it is necessary that the present program for medical students, interns, and residents in Veterans Administration hospitals be continued. Your reference committee therefore recommends that this portion of the resolution be rejected.

No. 17-A. Resolutions on the Late Dr. Edward D. Spalding

Dr. Robert L. Novy, Michigan, introduced the following resolutions, which were adopted by a unanimous rising vote, without referral:

WHEREAS, Dr. Edward D. Spalding, first alternate delegate representing the Michigan State Medical Society to the American Medical Association House of Delegates, was shot and killed as he departed from his office in Detroit to attend this Clinical Meeting of the American Medical Association; and

WHEREAS, At past sessions of this House, Dr. Spalding always was inspiring in his earnestness, in his energy, and in his brilliant mental capacity when attending to the duties assigned to him by the Michigan delegation to the American Medical Association House of Delegates; and

WHEREAS, Dr. Spalding, as an active practitioner of medicine, was a brilliant clinician as well as a militant leader in his espousal of private practice as opposed to compulsory schemes inimical to patients' welfare; therefore be it

Resolved, That the American Medical Association House of Delegates in session in St. Louis, Dec. 1-4, 1953, express its deep sense of loss in the tragic and abrupt passing of Dr. Edward D. Spalding and bespeaks its sincere sympathy to his bereaved survivors; and be it further

Resolved, That a copy of this resolution be prepared and be forwarded to Mrs. Spalding and to the Spalding family.

(Concluded in next issue.)

MEDICAL NEWS

CALIFORNIA

Research on Air Pollution.—A $78,084 grant has been made by the U. S. Public Health Service to the University of Southern California School of Medicine in Los Angeles to finance research on the effects of air pollution. Awarding of the research contract was announced on the 25th anniversary of the Southern California medical school, which was observed Sept. 24-25. Dr. Paul Kotin, Dr. Hurley Motley, John W. Mehl, Ph.D., and Hans Falk, Ph.D., will conduct the study.

Conference in Ophthalmology.—Stanford University School of Medicine, San Francisco, will present the annual postgraduate conference in ophthalmology, March 22-26, 1954. Registration will be open to 30 physicians who limit their practice to the treatment of diseases of the eye or of the eye, ear, nose, and throat. Instructors will be Drs. A. Edward Maumenee, Dohrmann K. Pischel, Jerome W. Bettman, Max Fine, Earle H. McBain, and Arthur J. Jampolsky. Information may be obtained from the Office of the Dean, Stanford University School of Medicine, 2398 Sacramento St., San Francisco 15.

Internists Meeting in Yosemite.—At the annual meeting in Yosemite National Park the California Society of Internal Medicine elected Dr. Walter Beckh, San Francisco, president, Dr. Paul I. Hoagland Jr., Pasadena, vice-president, and Dr. James H. Thompson, San Francisco, secretary-treasurer. The principal speaker, Homer W. Smith, Sc.D., professor of physiology, New York University College of Medicine, New York, discussed renal physiology, emphasizing "Salt and Water Balance." Other papers included "Acute Renal Failure—The Conservative Medical Management of Oliguria and Anuria" by Dr. James Hopper Jr. of the University of California Medical School, San Francisco, and "Acute Renal Failure—The Use of the Artificial Kidney" by Dr. Robert F. Maronde of the University of Southern California School of Medicine in Los Angeles. A medical economic forum was held to discuss the position of internists in the present day "surgical type" fee schedule.

COLORADO

State Medical Election.—At the annual meeting in Denver the Colorado State Medical Society chose the following officers: president, Dr. Claude D. Bonham, Boulder; president-elect, Dr. Samuel P. Newman, Denver; vice-president, Dr. Lawrence D. Buchanan, Wray; constitutional secretary (3 years), Dr. Irvin E. Hendryson, Denver; treasurer (3 years), Dr. Frank I. Nicks, Colorado Springs. The society will hold its next midwinter clinic at the Shirley-Savoy Hotel, Denver, Feb. 16-19, 1954, and the next annual session at the Broadmoor Hotel, Colorado Springs, Sept. 21-24.

Personal.—Dr. George W. Stiles, special research consultant, laboratory section, Colorado State Department of Public Health, Denver, has retired. Dr. Stiles came to the department in 1947 from the Bureau of Animal Industries.——Dr. Atha Thomas, chief of orthopedic surgery, University of Colorado School of Medicine, Denver, has been named chief of orthopedic service at National Jewish Hospital, which he has served as consultant orthopedic surgeon for many years.——Dr. Ruth Boring Howard, who has been acting chief of the hospitals standards and consultation section, Colorado State Department of Public Health, Denver, has been appointed chief of the maternal and child health section to replace Dr. Charles H. Dowding, who has accepted a position as deputy superintendent, maternal and child health, in the Milwaukee City Health Department.

Physicians are invited to send to this department items of news of general interest, for example, those relating to society activities, new hospitals, education and public health. Programs should be received at least three weeks before the date of meeting.

CONNECTICUT

Flight Surgeons Needed.—Chief Flight Surgeon William B. Smith of the Connecticut Department of Aeronautics announces that he needs Air Force or Navy-trained flight surgeons for his examining staff in several parts of the state. Address all communications to Dr. William B. Smith, Chief Flight Surgeon, Connecticut Department of Aeronautics, Brainard Field, Hartford.

ILLINOIS

Psychiatric Lectures.—In its series on treatment in psychiatry, the North Shore Health Resort (225 Sheridan Road, Winnetka) offers the lecture "The Role of a Psychiatrist in a Hospital" by Dr. Howard P. Rome, Mayo Clinic, Rochester, Minn., who will speak Jan. 6, 1954, 8 p. m., at the health resort.

Edgar County Celebrates 50th Anniversary.—The Edgar County Medical Society marked its 50th anniversary Nov. 5 at a banquet given at the Elks' Club in Paris by the society and the women's auxiliary. The honored guest was Dr. Francis M. Link, Paris, the only living charter member. Dr. Paul E. Fleener, president of the society, presided.

Chicago

Personal.—Dr. Samuel M. Feinberg, professor of medicine and director of the Allergy Research Laboratory, Northwestern University Medical School, discussed "Allergy to Chemotherapy" at Coronado, Calif., Dec. 9, in the symposium "Acute Infectious Diseases" sponsored by the California Academy of General Practice and the Lederle Laboratories.

Course in Electrocardiographic Interpretation.—A course in electrocardiographic interpretation for graduate physicians will be given at Michael Reese Hospital by Dr. Louis N. Katz, director of the cardiovascular department, Medical Research Institute, and associates, each Wednesday, 7-9 p. m. for 12 weeks, beginning Feb. 3, 1954. Information may be obtained on application to Mrs. Rivian H. Lewin, Cardiovascular Department, Michael Reese Hospital, Chicago 16.

Hospital News.—Dr. Karl A. Meyer, medical superintendent of Cook County institutions, announces the following appointments at Cook County Hospital: Dr. George C. Blaha, medical director, Dr. Samuel Hyman, assistant medical superintendent, and Dr. Sinclair Howard Armstrong Jr., director of medical education. Dr. Armstrong, who is professor of medicine at the University of Illinois College of Medicine, will also serve in an advisory capacity at the Hektoen Institute for Medical Research of the Cook County Hospital. ——A 27 million dollar slum redevelopment program involving 54 acres surrounding Michael Reese Hospital was recently approved by the Land Clearance Commission. The land will be cleared by the commission and sold to private interests for hospital expansion and rental housing purposes. Dr. Morris H. Kreeger, executive director of the hospital, has announced (1) an immediate 6 million dollar program to build a 112-bed medical service building, 40-bed convalescent center, central heating plant and new serum center and (2) an additional 4 million dollar program, to be completed in 10 years, which will include laboratory and research buildings, a center for studying the problems of the aging, and new nurses' and interns' residences.

IOWA

Public Medical Forums.—The Scott County Medical Society in cooperation with the Davenport Newspapers, Incorporated, held free physicians' public forums, Oct. 29, Nov. 3 and 19, and Dec. 3. Questions, submitted by the public and answered by a panel of physicians, concerned high and low blood pressure, weight, cancer, and rheumatic fever and rheumatic

V 15
1953

heart disease. There was an average attendance of about 800. Dr. Harry B. Weinberg, Davenport, was general chairman of the project.

Personal.—Dr. Grace M. Sawyer, superintendent of the Woodward State Hospital and School, was honored at a reception given by the employees, at which Dr. Ben T. Whitaker, Boone, past president of the Iowa State Medical Society, gave greetings for that organization and Dr. Frank A. Wilke, Perry, spoke in behalf of the Dallas-Guthrie Medical Society. Dr. Sawyer came to the hospital and school in 1923, went into private practice in Woodward in 1935, and in 1938 returned to the hospital as assistant superintendent, being appointed acting superintendent in 1951 and superintendent last July.

MARYLAND

Dr. Friedenwald Honored.—Dr. Edgar B. Friedenwald, professor of clinical pediatrics, emeritus, University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore, received a testimonial at the annual pediatric symposium, which read in part: "We, his friends, colleagues and former students hereby honor him, in appreciation of his loyal and faithful service to all children; to Mercy Hospital Pediatrics; and to the medical school."

Dr. Peabody Relinquishes Chief Consultant's Duties.—Dr. J. Winthrop Peabody, chief visiting consultant, Glenn Dale Sanatorium, Washington, D. C., since 1939, recently terminated his services in that capacity in order to devote more time to private practice and to organizational activities. As a consultant, he will visit Glenn Dale once a week for chest conferences. Dr. Peabody was at one time superintendent of the sanatorium. A member of the faculty of Georgetown University School of Medicine, Washington, D. C., since 1921, he is presently professor of diseases of the respiratory system. He is a member of the Founders' Group of the American College of Chest Physicians, which he has served as president (1942-1944) and chairman of the Council on Postgraduate Medical Education since 1944. His son, Dr. Joseph Winthrop Peabody Jr., is a resident in thoracic surgery at the Veterans Administration Hospital in Oteen, N. C.

MINNESOTA

Dr. Ravitch Speaks on Intussusception.—The annual Phi Delta Epsilon lectureship, "Present Concepts in the Management of Intussusception," will be given by Dr. Marcus M. Ravitch, director, department of surgery, Mount Sinai Hospital, New York, on Jan. 7, 1954, 8 p. m., at Owre Amphitheater, University of Minnesota Medical School, Minneapolis.

Personal.—Dr. Randall G. Sprague, Rochester, was presented the first annual J. Howard Reber memorial medal by the Philadelphia Metabolic Association at a meeting of the association in Philadelphia. The medal was awarded to Dr. Sprague for the contribution to the work in the field of diabetes.—— Dr. Henry E. Michelson, professor of dermatology, University of Minnesota Medical School, Minneapolis, recently delivered the William Allen Pusey memorial lecture of the Institute of Medicine of Chicago, "A Review and an Appraisal of the Present Knowledge of Lupus Erythematosus," before a joint meeting of the institute and the Chicago Dermatological Society in Chicago.

MISSOURI

University News.—The St. Louis University School of Medicine announces the following promotions: to the rank of associate professor, Drs. Wilbur K. Mueller and Don C. Weir, department of clinical radiology; and to assistant professor, Drs. James G. Janney Jr., James P. Murphy, J. Earl Smith, department of clinical medicine; Dr. Eugene G. Hamilton, clinical obstetrics and gynecology; Dr. Wilbert M. Gansloser, neurology and psychology; Drs. Ralph K. Earp, and Irwin B. Horwitz, orthopedic surgery; Dr. Edwin G. Eigel, clinical pediatrics; and Dr. Seymour Brown, clinical surgery.

NEBRASKA

Crippled Children's Clinics.—The clinics for crippled children are scheduled for the following dates: Jan. 9, 1954, Lexington, high school; Jan. 13, Norfolk, Norfolk State Hospital; Feb. 6, North Platte, high school; Feb. 20, Scottsbluff, St. Mary Hospital.

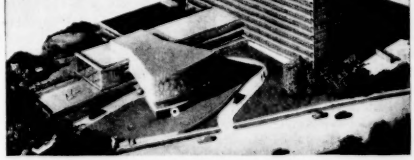
University News.—Creighton University recently honored six faculty members of the medical school in Omaha for 25 years' service. Plaques were presented to Drs. Michael J. Carey, Zeno N. Korth, Joseph W. McNamara, and James W. Va-Verka, Leo P. Clements, Ph.D., Omaha, and to Dr. Isaac Sternhill, Council Bluffs, Iowa.

NEW YORK

Society News.—At the meeting of the Onondaga County Medical Society and Syracuse Academy of Medicine (304 McCarthy Building, Syracuse) Jan. 5, 1954, Dr. J. Englebert Dunphy of the Peter Bent Brigham Hospital, Boston, will discuss "The Role of the Surgeon in the Diagnosis, Treatment and Long Range Management of Cancer."

Lecture on Anesthetic Emergencies.—Drs. Merel H. Harmel, professor of anesthesiology, and Sylvan N. Surks, assistant professor of anesthesiology, State University of New York College of Medicine at New York City, Brooklyn, will discuss "Anesthetic Emergencies," Jan. 7, 1954, 8:30 p. m. at the Jewish Sanitarium and Hospital for Chronic Diseases, 86 E. 49th St., Brooklyn 3.

Albert Einstein College of Medicine.—Ground was broken on Oct. 25 for the 10 million dollar Albert Einstein College of Medicine of Yeshiva University at Morris Park Avenue and Eastchester Road, the Bronx. The 10-story building, shown in



Albert Einstein College of Medicine of Yeshiva University.

the illustration, will be the first unit of a 25 million dollar medical teaching center and is expected to be ready for occupancy in the fall of 1955, when the first class (100 freshmen) will be admitted. The faculty will consist of 300 full-time instructors and a larger number of part-time teachers. The college will adjoin the 1,400-bed Bronx Municipal Hospital Center, which the city of New York is constructing at an estimated cost of 40 million dollars and which will be affiliated with the college and serve as its clinical teaching center. Adjoining the 10-story teaching research building will be a 3-story administrative and library wing, from which will be projected a 750-seat fan-shaped auditorium. The teaching and research wing will consist of a basement, ground floor, seven major laboratory and teaching floors, an animal institute, and a mechanical equipment floor. Each floor above the second will contain 14 laboratories. There will be three two-story lecture halls, and three conference rooms. Speakers at the ground-breaking ceremony included Gov. Thomas E. Dewey, Ralph J. Bunche, Ph.D., director of the division of trusteeship of the United Nations, Mayor Vincent R. Impellitteri, Samuel Belkin, Ph.D., president of Yeshiva University, and Dr. Marcus D. Kogel, New York commissioner of hospitals. Nelson A. Rockefeller, undersecretary of the Department of Health, Education, and Welfare, addressed the dinner celebration following the ceremonies.

New York City

Hospital News.—On Jan. 8, 1954, at 3 p. m., Dr. Jack Gross, assistant professor, department of anatomy, State University of New York College of Medicine at New York City, Brooklyn, will present "Some New Aspects of Thyroid Hormone Physiology" at the Montefiore Hospital for Chronic Diseases.

Meeting on Cancer.—The New York Cancer Society will discuss "Results to Date of Super-Radical Pelvic Surgery for Cancer," Jan. 5, 1954, 8:30 p. m., in the New York Academy of Medicine, Fifth Avenue at 103rd St. Dr. Perry B. Hudson will have as his topic "Cancer of the Bladder and Prostate" (discussion, Dr. Willet F. Whitmore Jr.), and Dr. Alexander Brunschwig will present "Cancer of the Uterus" (discussion, Dr. Howard C. Taylor Jr.). Physicians and medical students are invited.

Pfeiffer Research Foundation.—According to the will of the late Gustavus A. Pfeiffer, four-fifths of his residuary estate will go to the Gustavus and Louise Pfeiffer Research Foundation, which he and his wife established in 1942 for improving public health through the advancement of medicine and pharmacy. The former head of William R. Warner & Co., pharmaceutical manufacturers, and retired president of Richard Hudnut left an estate estimated at more than 10 million dollars.

Silkworth Memorial Service.—The Knickerbocker Hospital announces the opening of the Silkworth Memorial Service devoted to the study and treatment of deviant eating and drinking habits. Emphasis will be given to obesity and alcoholism and the inter-relation of the physiological and medical aspects and the patient's emotional and social problems. A diagnostic evaluation, carried out by the service on all referred patients, will cover the medical, psychological, and social areas. Dr. Giorgio Lolli, director of the new service, will continue to be medical director of the Yale Plan Clinic, Yale University, New Haven, Conn., a position he has held for many years. To accept the direction of the Silkworth Memorial Service, he has resigned from the position of medical director of the Connecticut Commission on Alcoholism. He will, however, continue his association with the commission as a consultant.

OKLAHOMA

Surgery Course Postponed.—The University of Oklahoma School of Medicine, Oklahoma City, announces that the postgraduate study course in surgery originally scheduled for Dec. 9-11 has been postponed to Jan. 6-8, 1954. In addition to the staff of the School of Medicine, the faculty will include three visiting guest speakers: Dr. John T. Reynolds, associate professor of surgery, University of Illinois College of Medicine, Chicago, who will discuss problems of the gastrointestinal tract; Dr. Michael E. DeBakey, professor of surgery, Baylor University College of Medicine, Houston, Texas, who will speak on surgical management of diseases of the aorta; and Dr. John W. Duckett, professor of clinical surgery, Southwestern Medical School, Dallas, Texas, who will present some problems of pediatric surgery.

TENNESSEE

Fifty Year Club.—At a special dinner meeting of the Memphis-Shelby County Medical Society, Oct. 6, at the Memphis Country Club, Drs. George R. Livermore, William H. Lovejoy, and Wallace P. Moore of Memphis and Dr. Logan C. McVay of Marion, Ark., were awarded certificates of recognition for their long service by the society and were presented with 50 year gold pins from the Tennessee State Medical Association. Dr. McVay recently received a 50 year pin from the Arkansas Medical Society.

TEXAS

Narcotic Violation.—Dr. Thomas Calvin Brackeen, 770½ Neches, Beaumont, pleaded guilty on Nov. 4 in the U. S. District Court at Beaumont to a violation of the federal narcotic law. On Nov. 5, he was sentenced to serve two years each on five counts, to run concurrently, and was fined $300 on each of the five counts. The sentence was suspended, and he was placed on probation for three years.

University News.—Dr. William F. Mengert, professor of obstetrics and gynecology, Southwestern Medical School of the University of Texas, Dallas, has been appointed chairman of the obstetrics and gynecology test committee of the National Board of Medical Examiners.——At the recent meeting of the Association of American Medical Colleges in Atlantic City, Dr. George N. Aagaard, dean of Southwestern Medical School of the University of Texas, was elected a member of the executive council for a three year term.

WEST VIRGINIA

Civil Defense Meeting.—At a combined staff meeting of the state and local health department personnel in Charleston, Dec. 14-15, Dr. Newman H. Dyer, state director of health, presided over a civil defense meeting of the medical and health services division of the West Virginia civil defense program. Dr. Henry C. Huntley, formerly of Charleston but now medical officer of the Regional Office, Federal Civil Defense Administration, West Chester, Pa., discussed the "Status of the Civil Defense Program at Regional Level," and Lt. Col. Edgar M. Sites, deputy C. D. director for West Virginia, presented "The General State Program." Dr. Leon A. Dickerson, director, Kanawha-Charleston Health Department, spoke on the role of the health officer, medical profession, advisory committee, voluntary agency, and the hospital in civil defense. The program also featured addresses by Dr. James S. Klumpp, Huntington, president, West Virginia State Medical Association; Dr. Russell Kessel, Charleston, president-elect; Mr. T. A. Baxter, state representative of the American Red Cross; and Mr. William R. Huff, executive secretary of the West Virginia Hospital Association.

ALASKA

Personal.—Dr. Arthur N. Wilson of Ketchikan has been appointed a member of the Alaska Board of Health.——Dr. Hazel I. Blair, Juneau, senior field physician for the health department, has been granted a year's leave of absence.——Dr. John T. Gentry, who was assigned by the U. S. Public Health Service as the first full-time health officer for the Greater Anchorage Health District in September, 1952, has resigned to fulfil a service obligation at the New York State Department of Health that was postponed because of his work with the U. S. Public Health Service.

Mental Health Association.—The Juneau Mental Health Association has elected its first board of directors, which includes Drs. Norman J. Diamond and Joseph O. Rude, Juneau. The organization, which consists of 41 members, was formed "to promote good mental health, to prevent mental and emotional illness, and to speed the day when any person who becomes mentally and emotionally ill will have the best possible chance to get well." Working committees include legislative, education, public relations, and mental health facilities. One of the first activities of the legislative committee is its work to encourage passage of HR 1217, a bill presently in congress, which seeks to improve treatment and care of Alaska's mentally ill. The association may be contacted through Mrs. Tickell, Box 1177, Juneau.

LATIN AMERICA

School for Study of Ophthalmology.—The Liga contra la Ceguera of Cuba will open a new school of specialization in ophthalmology in Havana, offering a two year course with theoretical and practical training and a one year postgraduate course. Dr. Thomas R. Yanes is head of the school. The first course will start in July, 1954, consisting of four semesters, up to a total of 800 hours. The tuition is $500, payable in two semesters. The first matriculation is restricted to 20 candidates, including Americans and Latin Americans, in practice for less than five years. Information may be obtained from the secretary of the school, M. Farinas Pelletier, Liga contra la Ceguera, Apartado de Correos 4053, Havana, Cuba.

V 15
195

GENERAL

Reports Wanted on Disaster Research.—The National Academy of Sciences-National Research Council has set up a committee on disaster studies under the council's division of anthropology and psychology. Because of the interest in disaster research, the many disciplines involved, and the great need for exchange of information, the committee has established a clearinghouse for disaster studies, is anxious to receive reprints and reports, especially unpublished reports, on disaster studies, and would appreciate communication with the investigators of any "in progress" studies. Correspondence may be addressed to the chairman, Mr. C. M. Louttit, National Academy of Sciences, 2101 Constitution Ave., Washington 25, D. C.

Cerebral Palsy Grants.—During the 12 months ending Sept. 30, United Cerebral Palsy allotted research and training grants totaling $392,874. Research grants, $254,940, reflected a 69% increase over the previous year. The new grants, which have widened the scope of research being sponsored by United Cerebral Palsy to include such investigations as a study of breathing movements in cerebral palsy and a study of factors promoting regeneration of nerve fibers in the central nervous system, are in addition to long-range studies begun in previous years. This year there were seven workshops, at which 116 educational and professional specialists and 52 counselors of the handicapped and social workers learned about special education and vocational planning for the palsied.

Society News.—At the annual meeting, Oct. 30-31, in Fort Worth, Texas, the **American Academy for Cerebral Palsy** chose Dr. Meyer A. Perlstein, Chicago, president and Dr. Lenox D. Baker, Durham, N. C., president-elect.——Officers of the **New England Society of Anesthesiologists** for the coming year are Dr. Stevens J. Martin, Hartford, Conn., president, Dr. Elihu Saklad, Providence, R. I., vice-president, and Dr. Francis J. Audin, Boston, secretary-treasurer.——At the annual meeting of the **Neurosurgical Society of America** at Colorado Springs, Colo., the following officers were elected: Dr. C. Douglas Hawkes, Memphis, president; Drs. Carl J. Graf, Buffalo, and Charles L. Neill, Jackson, Miss., vice-presidents; Dr. I. Joshua Speigel, Chicago, treasurer; and Dr. Lester A. Mount, New York, secretary.

Mississippi Valley Essay Contest.—The Mississippi Valley Medical Society offers a cash prize of $100, a gold medal, and a certificate of award for the best unpublished essay on any subject of general medical interest and of practical value to the general practitioners. Contestants must be members of the American Medical Association who are residents and citizens of the United States. The winner of the 1954 contest will be invited to present his contribution before the 19th annual meeting of the Mississippi Valley Medical Society, Chicago, Sept. 23-24, 1954. Contributions must be typewritten in English in manuscript form, submitted in five copies, not to exceed 5,000 words, and received not later than May 1. Details may be secured from Dr. Harold Swanberg, secretary, Mississippi Valley Medical Society, 209-224 W.C.U. Building, Quincy, Ill.

Meeting for Hospital Consultants.—At the annual convention of the American Association for the Advancement of Science the association will hold a joint session with the American Association of Hospital Consultants, Dec. 30, 9:30 a. m., at the Hotel Statler, Boston. Dr. E. Michael Bluestone, New York, president, American Association of Hospital Consultants, will preside over the following program on the research function of the hospital:

Varieties of Laboratory Service in Hospitals, Jack Masur, Washington, D. C.

A Hospital Research Program—Experiences at the Massachusetts General Hospital, Dean A. Clark, Boston.

Developments in Physical and Chemical Research (Including Atomic Research) Which Have a Relationship to Hospital Laboratories, G. Harvey Agnew, Toronto, Canada.

The discussion will be opened by Dr. Cecil G. Sheps, Boston.

Meeting on Premedical Education.—At the meeting of the American Association for the Advancement of Science, Boston, Alpha Epsilon Delta, national premedical honor society, will sponsor a luncheon at the Hotel Statler, 12:15 p. m., Dec. 29. "The Need for More Well Qualified Applicants for the Medical Schools" will be discussed by Dr. James M. Faulkner, dean, Boston University School of Medicine, and "Suggestions on a Second National Conference on Premedical Education" will be presented by the fraternity's national secretary, Maurice L. Moore. Informal round-table discussion will follow. Members of Alpha Epsilon Delta and others interested in premedical education are invited to attend the luncheon and program. Reservations for luncheon ($2.50, including gratuities) should be made through the National Secretary, Alpha Epsilon Delta, 7 Brookside Circle, Bronxville 8, N. Y.

Committee to Certify Mental Hospital Administrators.—The American Psychiatric Association has set up a committee to certify physicians as "qualified mental hospital administrators," in order to help ensure that the chief executives of mental hospitals shall be physicians not only adequately trained in psychiatry but also skilled in business and personnel management, community relations, budget control, procurement, and other essential administrative techniques. The committee, which will conduct examinations periodically, comprises: Drs. Francis J. Braceland, Hartford, Conn. (chairman); William B. Terhune, New Canaan, Conn.; George W. Jackson, Topeka, Kan.; Walter H. Baer, Peoria, Ill.; Granville L. Jones, Williamsburg, Va.; Frank F. Tallman, Los Angeles; Arthur M. Gee, Essondale, British Columbia, Canada; Harold W. Sterling, North Little Rock, Ark.; Jack R. Ewalt, Boston; and G. Wilse Robinson, Kansas City, Mo. Information may be obtained from the secretary, Dr. Crawford N. Baganz, Manager, Veterans Administration Hospital, Lyons, N. J.

FOREIGN

Society News.—The Association of Pediatricians of India, of which G. Coelho is chairman and R. V. Sanzgiri, secretary, has its headquarters at Back Bay View, New Queen's Road, Bombay 4.

International Orthopedic Surgery Meeting.—The sixth congress of the International Society of Orthopaedic Surgery and Traumatology will be held in Bern, Switzerland, Aug. 30 to Sept. 3, 1954. The tentative program includes treatment of scoliosis, physiology of sport, physiology of movement, chemical aspects of orthopedic surgery, bone and joint tuberculosis, bone and joint pathology, and surgery of the hand. Visits to nearby hospitals, research centers, and other institutions have been scheduled, as well as excursions at the close of the congress. Correspondence should be addressed to the secretary-general of the society, Dr. Jean Delchef, 34, rue Montoyer, Brussells, Belgium. Application should be made before May 31.

Prize for Study on Alcoholism.—The Society for the Study of Addiction has opened the competition for the Hubert Norman prize of 100 guineas (about $296) to stimulate research on the cause and prevention of addiction. The competition is open to both medical and nonmedical workers throughout the world, only officers of the society being ineligible. The subject of the first Hubert Norman prize will be: "Study or Investigation of Substances, Other Than Antabuse or Its Derivatives, Causing Distaste, Disinclination, or Dislike for Alcohol." Three copies of the manuscript, typewritten in English, should reach the editor of the *British Journal of Addiction*, 34 Addison Road, London, W.14, not later than Dec. 31, 1954. The award will be made in January, 1955. The selected contribution may be published in the journal and the winner invited to present it at a meeting of the society. Inquiries concerning the competition should be addressed to the editor of the journal.

CORRECTIONS

Dr. Sabin Not First Woman Graduate of Johns Hopkins.—The statement that Dr. Florence R. Sabin was the first woman to be admitted to and to graduate from Johns Hopkins University School of Medicine, which appeared in THE JOURNAL, Nov. 14, page 1030, was erroneous. Dr. Sabin was among the 13 women who received the M.D. degree in 1900 from Johns Hopkins. The first graduating class (1897) contained one woman, Mary Secord Packard.

Hans L. Popper.—The senior author of the Clinical Note in THE JOURNAL, Nov. 21, 1953, page 1095, entitled "Ligation of Hepatic Artery for Portal Hypertension" was Hans Leopold Popper, M.D. A second physician in Chicago with a similar name (Hans Popper, M.D.) is on the staff at the Hektoen Institute of the Cook County Hospital.

The Bolen Test for Cancer.—In queries and Minor Notes in THE JOURNAL, June 21, 1952, page 797, the reference to the two journals mentioned in the last three lines of the first paragraph in the answer were erroneous and should have referred to the *American Journal of Surgery*, November, 1950, and to the *American Journal of Digestive Diseases*, February, 1950.

EXAMINATIONS AND LICENSURE

NATIONAL BOARD OF MEDICAL EXAMINERS: *Parts I and II.* Held in approved medical schools where there are five or more candidates. Dates: Feb 9-10; April 20-21 (Part II only); June 22-23; Sept. 7-8 (Part I only). Candidates may file examinations at any time but the National Board must receive them at least six weeks before the date of the examination they wish to take. New candidates should apply by formal registration; registered candidates should notify the board by letter. Sec., Dr. John P. Hubbard, 133 S. 36th St., Philadelphia 4.

BOARDS OF MEDICAL EXAMINERS

ALABAMA: *Examination.* Montgomery, June 22-24, 1954. Sec., Dr. D. G. Gill, 537 Dexter Ave., Montgomery.

DELAWARE: Dover, Jan. 12-14, 1954. Sec., Dr. Joseph S. McDaniel, 229 South State St., Dover.

GUAM: The Commission on Licensure will meet whenever a candidate appears or submits his credentials. Director of Medical Services, Guam Memorial Hospital, Agana.

HAWAII: Honolulu, Jan. 11-14. *Examination.* Sec., Dr. I. L. Tilden, 1020 Kapiolani St., Honolulu.

IDAHO: Boise, Jan. 11-13, 1954. Executive Secretary, Mr. Armand L. Bird, 364 Sonna Bldg., Boise.

ILLINOIS: *Examination and Reciprocity.* Chicago, Jan. 26-28. Supt. of Registration, Mr. Fredric B. Selcke, Capitol Bldg., Springfield.

INDIANA: *Examination.* Indianapolis, June 16-18. Exec. Sec., Miss Ruth V. Kirk, 538 K of P Bldg., Indianapolis.

MASSACHUSETTS: *Examination.* Boston, Jan. 12-15. Sec., Dr. Robert C. Cochrane, Room 37, State House, Boston 33.

MICHIGAN:* *Examination.* Detroit and Ann Arbor, June 1954. Sec., Dr. J. Earl McIntyre, 202-4 Hollister Bldg., Lansing 8.

MONTANA: *Reciprocity.* Helena, April 5. *Examination.* Helena, April 6-7. Sec., Dr. S. A. Cooney, 214 Power Block, Helena.

NEBRASKA:* *Examination.* Omaha, June 1954. Director, Mr. Husted K. Watson, 1009 State Capitol Bldg., Lincoln.

NEVADA:* *Examination and Reciprocity.* Reno, Jan. 6. Sec., Dr. George H. Ross, 112 Curry St., Carson City.

NEW HAMPSHIRE: *Examination and Reciprocity.* Concord, March 10. Sec., Dr. John S. Wheeler, 107 State House, Concord.

NEW MEXICO:* *Examination and Reciprocity.* Santa Fe, April 12-13. Sec., Dr. R. C. Derbyshire, 227 E. Palace Ave., Santa Fe.

NEW YORK: *Examination.* Albany, Buffalo, Syracuse and New York City, Feb. 16-19. Sec., Dr. Stiles D. Ezell, 23 S. Pearl St., Albany.

NORTH CAROLINA: *Reciprocity.* Winston-Salem, Jan. 18. Sec., Dr. Joseph J. Combs, 716 Professional Bldg., Raleigh.

NORTH DAKOTA: *Examination.* Grand Forks, Jan. 6-9, 1954. *Reciprocity.* Grand Forks, Jan. 9. Sec., Dr. C. J. Glaspel, Grafton.

OKLAHOMA:* *Examination.* Oklahoma City, June 9-10. Sec., Dr. Clinton Gallaher, 813 Braniff Bldg., Oklahoma City.

OREGON:* *Examination.* Portland, Jan. 4-5. *Reciprocity.* Portland, Jan. 14-16. Sec., Mr. Howard I. Bobbitt, 609 Failing Bldg., Portland.

PENNSYLVANIA: *Examination.* Philadelphia, January 1954. Acting Secretary, Mrs. Margaret G. Steiner, Box 911, Harrisburg.

RHODE ISLAND:* *Examination.* Providence, Jan. 7-8. Admin. of Professional Regulation, Mr. Thomas B. Casey, 366 State Office Bldg., Providence.

SOUTH CAROLINA: *Reciprocity.* Columbia, Feb. 1. Sec., Mr. N. B. Heyward, 1329 Blanding St., Columbia.

SOUTH DAKOTA:* *Examination.* Sioux Falls, Jan. 19-20, 1954. Reciprocity can be obtained at any time between meetings of board. Executive Secretary, Mr. John C. Foster, 300 First National Bank Bldg., Sioux Falls.

VERMONT: *Examination.* Burlington, Feb. 1954. Sec., Dr. F. J. Lawliss, Richford.

WASHINGTON:* *Examination.* Seattle, Jan. 10-13. *Reciprocity.* Seattle, Jan. 10. Sec., Mr. Edward C. Dohm, Department of Licenses, Olympia.

WEST VIRGINIA: *Examination and Reciprocity.* Charleston, Jan. 11-13. Sec., Dr. N. H. Dyer, State Office Bldg., Charleston 5.

WISCONSIN:* *Examination and Reciprocity.* Madison, Jan. 12-14, 1954. Sec., Dr. A. G. Koehler, 46 Washington Blvd., Oshkosh.

WYOMING: *Oral Examination and Reciprocity.* Cheyenne, Feb. 1. Sec., Dr. Franklin D. Yoder, State Office Bldg., Cheyenne.

BOARDS OF EXAMINERS IN THE BASIC SCIENCES

ALASKA: On application. Juneau or other towns in Territory as decided by Board. *Reciprocity.* On application. Sec., Dr. C. Earl Albrecht, Box 1931, Juneau.

CONNECTICUT: *Examination.* New Haven, Feb. 13. Address: State Board of Healing Arts, 52 Whitney Ave., New Haven 10.

IOWA: *Examination.* Des Moines, Jan. 12. Sec., Dr. Ben H. Peterson, Coe College, Cedar Rapids.

MICHIGAN: *Examination.* Detroit and Ann Arbor, Feb. 12-13. Sec., Mrs. Anne Baker, 410 W. Allegan St., Lansing 15.

MINNESOTA: *Examination.* Minneapolis, Jan. 5-6. Sec., Dr. Raymond N. Bieter, 105 Millard Hall, Minneapolis 14.

NEVADA: *Examination.* Reno, Jan. 5. Sec., Dr. Donald G. Cooney, Box 9005, University of Nevada, Reno.

NEW MEXICO: *Examination.* Santa Fe, Jan. 17. Sec., Miss Marguerite K. Cantrell, Box 1522, Santa Fe.

OKLAHOMA: *Examination.* Oklahoma City, April 16-17. Sec., Dr. Clinton Gallaher, 813 Braniff Bldg., Oklahoma City.

OREGON: *Examination.* Portland, March 6, June 5, Sept. 11 and Dec. 4. Sec., Mr. Charles D. Byrne, State Board of Higher Education, Eugene.

TENNESSEE: *Examination.* Memphis, Dec. 30-31. Sec., Dr. O. W. Hyman, 874 Union Ave., Memphis 3.

TEXAS: *Examination.* April 1954. Location determined by number of applicants from different sections of the state. Sec., Brother Raphael Wilson, C.S.C., 407 Perry-Brooke Bldg., Austin.

WASHINGTON: *Examination.* Seattle, Jan. 6-7. Sec., Mr. Edward C. Dohm, Department of Licenses, Olympia.

WISCONSIN: *Examination.* Madison, April 3 and June 5. Final date for filing application is March 26 and May 28. Sec., Dr. W. H. Barber, 621 Ransom St., Ripon.

*Basic Science Certificate required.

MEETINGS

AMERICAN MEDICAL ASSOCIATION: Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Secretary.

1954 Annual Meeting, San Francisco, June 21-25.

1954 Clinical Meeting, Miami, Florida, Nov. 30-Dec. 3.

1955 Annual Meeting, Atlantic City, N. J., June 6-10.

1955 Clinical Meeting, Boston, Nov. 29-Dec. 2.

1956 Annual Meeting, Chicago, June 11-15.

ANNUAL CONGRESS ON MEDICAL EDUCATION AND LICENSURE, Palmer House, Chicago, Feb. 7-9. Dr. Edward L. Turner, 535 N. Dearborn St., Chicago 10, Secretary.

AMERICAN ACADEMY OF ALLERGY, Shamrock Hotel, Houston, Texas, Feb. 1-3. Dr. Alan G. Cazort, 1425 West 7th St., Little Rock, Ark., Secretary.

AMERICAN ACADEMY OF OCCUPATIONAL MEDICINE, John Marshall Hotel, Richmond, Va., Feb. 11-12. Dr. Leonard J. Goldwater, 600 W. 168th St., New York 32, Secretary.

AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS, Palmer House, Chicago, Jan. 23-28. Dr. John R. Norcross, 122 S. Michigan Blvd., Chicago 3, Secretary.

AMERICAN COLLEGE OF RADIOLOGY, Drake Hotel, Chicago, Feb. 5. Mr. William C. Stronach, 20 N. Wacker Drive, Chicago 6, Executive Secretary.

AMERICAN FEDERATION FOR CLINICAL RESEARCH:

EASTERN SECTION, Amphitheater, Children's Medical Center, Boston, Jan. 4. Dr. Joseph R. Stanton, 482 Beacon St., Boston 15, Chairman.

SOUTHERN SECTION, Jung Hotel, New Orleans, Jan. 29. Dr. William Parson, University of Virginia School of Medicine, Charlottesville, Va., Chairman.

WESTERN SECTION, Auditorium, University of Oregon Medical School, Portland, Ore., Jan. 28. Dr. I. S. Edelman, University of California Medical Center, San Francisco Hospital, San Francisco 15, Secretary.

V 1
195

AMERICAN LARYNGOLOGICAL, RHINOLOGICAL AND OTOLOGICAL SOCIETY:

EASTERN SECTION. Waldorf-Astoria, New York, Jan. 8. Dr. Daniel S. Cunning, 118 E. 53d St., New York 22, Chairman.

MIDDLE SECTION, Park Plaza Hotel, St. Louis, Jan. 18. Dr. French K. Hansel, 634 N. Grand Blvd., St. Louis, Chairman.

SOUTHERN SECTION, Brown Hotel, Louisville, Ky., Jan. 16. Dr. William C. Wolfe, 1012 Heyburn Bldg., Louisville 2, Ky., Chairman.

WESTERN SECTION, University of Oregon Medical School, Portland, Ore., Feb. 6. Dr. Guy L. Boyden, 1735 N Wheeler Ave., Portland 12, Ore., Chairman.

AMERICAN ORTHOPSYCHIATRIC ASSOCIATION, Hotel New Yorker, New York, Feb. 11-13 Dr. Marion F. Langer, Room, 303 Lexington Ave., New York 16, Secretary.

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Palmer House, Chicago, Feb. 10-12. Mr. Albert G. Hahn, Protestant Deaconess Hospital, Evansville, Ind., Executive Secretary.

AMERICAN SOCIETY FOR SURGERY OF THE HAND, Palmer House, Chicago, Jan. 22. Dr. George V. Webster, 960 East Green St., Pasadena 1, Calif., Secretary.

CENTRAL SURGICAL ASSOCIATION, Statler Hotel, Detroit, Feb. 18-20. Dr. Robert M. Zollinger, University Hospital, Columbus 10, Ohio, Secretary.

NORTHWEST SOCIETY FOR CLINICAL RESEARCH, Portland, Ore., Jan. 28. Dr. Arthur L. Rogers, 1216 S.W. Yamhill St., Portland, Ore., Secretary.

REGIONAL MEETINGS, AMERICAN COLLEGE OF PHYSICIANS:

EASTERN PENNSYLVANIA, Philadelphia, Jan. 15. Dr. Thomas M. McMillan, 330 S. Ninth St., Philadelphia 7, Governor.

SECTIONAL MEETINGS, AMERICAN COLLEGE OF SURGEONS: Charlotte, N. C., Hotel Charlotte, Feb. 1-3. Dr. Thomas D. Sparrow, 403 North Tryon St., Charlotte 2, N. C., Chairman.

SOCIETY OF UNIVERSITY SURGEONS, Sheraton Hotel, Rochester, N. Y., Feb. 11-13. Dr. C. Rollins Hanlon, 1325 South Grand Blvd., St. Louis, Secretary.

WESTERN SOCIETY FOR CLINICAL RESEARCH, Portland, Ore., Jan. 29-30. Dr. Herbert N. Hultgren, Stanford Hospital, San Francisco 15, Secretary.

FOREIGN

ASSOCIATION OF SURGEONS OF GREAT BRITAIN AND IRELAND, Leeds, England, May 13-15, 1954. Dr. Henry W. S. Wright, 45 Lincoln's Inn Fields, London W.C.2, England, Honorary Secretary.

BRITISH MEDICAL ASSOCIATION, Glasgow, Scotland, July 1-9, 1954. Dr. A. Macrae, B.M.A. House, Tavistock Square, London, W.C.1, England, Secretary.

CANADIAN MEDICAL ASSOCIATION, Vancouver, B. C., Canada, June 14-18, 1954. Dr. T. C. Routley, 135 St. Clair Ave. W., Toronto 5, Ont., Canada, General Secretary.

CONFERENCE OF INTERNATIONAL UNION AGAINST TUBERCULOSIS, Madrid, Spain, Sept. 26-Oct. 2, 1954. Secretariat, Escuela de Tisiologia, Ciudad Universitaria, Madrid, Spain.

CONGRESS OF INTERNATIONAL ANESTHESIA RESEARCH SOCIETY, Los Angeles, Calif., U. S. A., Oct. 4-7, 1954. For information write: Dr. T. H. Seldon, 102-110 Second Avenue S. W., Rochester, Minn., U. S. A.

CONGRESS OF INTERNATIONAL ASSOCIATION FOR THE PREVENTION OF BLINDNESS, New York, N. Y., U. S. A., Sept. 12-17, 1954. Professor Franceschetti, 2 Avenue Mirmot, Geneva, Switzerland, Secretary-General.

CONGRESS OF INTERNATIONAL SOCIETY OF SURGERY, Paris, France, May 21-22, 1954. Dr. L. Dejardin, 141, rue Belliard, Brussels, Belgium, General Secretary.

HEALTH CONGRESS OF THE ROYAL SANITARY INSTITUTE, Scarborough, England, April 27-30. Mr. P. Arthur Wells, Royal Sanitary Institute, 90 Buckingham Palace Road, London, S.W.1, England, Secretary.

INTERNATIONAL CANCER CONGRESS, Sao Paulo, Brazil, July 23-29, 1954. Prof. A. Prudente, 171 rua Benjamin Constante, Sao Paulo, Brazil, President.

INTERNATIONAL CONFERENCE ON THROMBOSIS AND EMBOLISM, Basle, Switzerland, July 15-19, 1954. Dr. W. Merz, Chief Medical Officer, Gynecological Clinic, University of Basle, Basle, Switzerland, Hon. Secretary.

INTERNATIONAL CONGRESS ON CHILD PSYCHIATRY, University of Toronto, Toronto, Ontario, Canada, Aug. 13-14, 1954. Miss Helen Speyer, International Association for Child Psychiatry, 1790 Broadway, New York 19, New York, U. S. A., Executive Officer.

INTERNATIONAL CONGRESS OF CLINICAL PATHOLOGY., Washington, D. C., U. S. A., Sept. 6-10, 1954. Dr. Robert A Moore, Washington University School of Medicine, St. Louis 10, Missouri, U. S. A., Chairman, Committee on Arrangements.

INTERNATIONAL CONGRESS ON DISEASES OF THE CHEST, Barcelona, Spain, Oct. 4-8, 1954 Mr. Murray Kornfeld, 112 East Chestnut St., Chicago 11, Illinois, Executive Secretary.

INTERNATIONAL CONGRESS ON GROUP PSYCHOTHERAPY, Toronto, Ont., Canada, Aug. 12-14, 1954. Dr. J. L. Moreno, Room 327, 101 Park Ave., New York 17, N. Y., U. S. A., Director of Organizing Committee.

INTERNATIONAL CONGRESS OF HEMATOLOGY, Paris, Sept. 6-11, 1954. Dr. Jean Bernard, 86 rue d'Assas, Paris 6e, France, Secretary.

INTERNATIONAL CONGRESS OF THE HISTORY OF MEDICINE, Rome and Salerno, Italy, Sept. 13-20, 1954. For information write: Segreteria XIV Congresso Internazionale di Storia della Medicina, Instituto di Storia della Medicine, Citta Universitaria, Rome, Italy.

INTERNATIONAL CONGRESS OF HYDROCLIMATISM AND THALASSOTHERAPY, Dubrovnik, Yugoslavia, May 8-16, 1954. Prof. C. Plavsic, Zeleni venac 1, Belgrade, Yugoslavia, Secretary General.

INTERNATIONAL CONGRESS OF INDUSTRIAL MEDICINE, Naples, Italy, Sept. 13-19, 1954. Professor Scipione Caccuri, Director, Institute of Industrial Medicine Policlinico, Naples, Italy, Chairman, Organizing Committee.

INTERNATIONAL CONGRESS OF INTERNAL MEDICINE, Stockholm, Sweden, Sept. 15-18, 1954. Professor Anders Kristenson, Karolinska Sjukhuset, Stockholm 60, Sweden, Secretary-General.

INTERNATIONAL CONGRESS OF INTERNATIONAL COLLEGE OF SURGEONS, São Paulo, Brazil, April 26-May 2, 1954. Dr. Max Thorek, 1516 Lake Shore Drive, Chicago, Illinois, U. S. A., Secretary-General.

INTERNATIONAL CONGRESS ON MENTAL HEALTH, University of Toronto, Toronto, Ontario, Canada, Aug. 14-21, 1954. For information write: Executive Officer, International Congress on Mental Health, 111 St. George St., Toronto, Ontario, Canada.

INTERNATIONAL CONGRESS OF NUTRITION, Amsterdam, Netherlands, Sept. 14-18, 1954. For information write: Dr. M. van Eekelen, Centraal Instituut voor Voedingsonderzoek T.N.O., 61 Catharynesingel, Utrecht, Netherlands.

INTERNATIONAL CONGRESS ON OBSTETRICS AND GYNECOLOGY, Geneva, Switzerland, July 26-31, 1954. Dr H. de Watteville, Maternité Hôpital Cantonal, Geneva, Switzerland, President.

INTERNATIONAL CONGRESS OF OPHTHALMOLOGY, University of Montreal and McGill University, Montreal, Canada, Sept. 10-11, 1954, and Waldorf-Astoria, New York, N. Y., U. S. A., Sept. 12-17, 1954. Dr. William L. Benedict, 100 First Avenue Building, Rochester, Minnesota, U. S. A., Secretary-General.

INTERNATIONAL CONGRESS OF ORTHOPEDIC SURGERY AND TRAUMATOLOGY, Berne, Switzerland, Aug. 30-Sept. 3, 1954. For information write: Professor M. Dubois, Isle-Hospital, Berne, Switzerland.

INTERNATIONAL CONGRESS OF PSYCHOLOGY, Montreal, Canada, June 7-12, 1954. For information write: Prof. H. S. Langfeld, International Union of Scientific Psychology, Eno Hall, Princeton University, Princeton, N. J., U. S. A.

INTERNATIONAL CONGRESS FOR PSYCHOTHERAPY, Zurich, Switzerland, July 21-24, 1954. Dr. H. K. Fierz, Theaterstrasse 12, Zurich 1, Switzerland, Secretary General.

INTERNATIONAL GERONTOLOGICAL CONGRESS, London and Oxford, England, July 12-22, 1954. Prof. R. E. Tunbridge, General Infirmary, Department of Medicine, The University, Leeds, England, President.

INTERNATIONAL POLIOMYELITIS CONGRESS, Rome, Italy, Sept. 6-10, 1954. Mr. Stanley E. Henwood, 120 Broadway, New York 5, N. Y., U. S. A., Executive Secretary.

INTERNATIONAL SOCIETY OF BLOOD TRANSFUSION, Paris, France, Sept. 12-19, 1954. For information write: Colonel Julliard, Societe Internationale de Transfusion Sanguine, 53 Boulevard Diderot, Paris 12e, France.

INTERNATIONAL SOCIETY FOR CELL BIOLOGY, Leiden, Netherlands, Sept. 2-9, 1954. Professor Peter J. Gaillard, University of Leiden, Leiden, Netherlands, Secretary.

INTERNATIONAL SOCIETY OF GEOGRAPHICAL PATHOLOGY, Washington, D. C., U. S. A., Sept. 6-10, 1954. Professor Fred C. Roulet, Hebelstrasse 24, Basle, Switzerland, Secretary-General.

JOURNEES MEDICALES, Paris, France, April 21-25, 1954. For information write: Secretariat of the Journees, 12, rue Pierre-Geofroix, Colombes (Seine) France.

LATIN AMERICAN CONGRESS OF OTORHINOLARYNGOLOGY, Caracas, Venezuela, Feb. 21-25, 1954. Dr. Victorino Marquez Reveron, Centro, Medico, Caracas, Venezuela, Secretary-General.

LATIN AMERICAN CONGRESS OF PHYSICAL MEDICINE, Medellin, Columbia, South America, Feb. 15-20, 1954. Dr. Cassius Lopez de Victoria, 176 East 71st St., New York 21, N. Y., U. S. A., Executive Director.

PAN AMERICAN CONGRESS OF OPHTHALMOLOGY (Intermin), São Paulo, Brazil, June 17-21, 1954. Dr. Moacyr E. Alvaro, São Paulo, Brazil, President.

PAN AMERICAN CONGRESS OF OTORHINOLARYNGOLOGY AND BRONCHOESOPHAGOLOGY, Mexico, D.F., Mexico, Feb. 28-March 4, 1954. Dr. Pedro Hernandez Gonzalo, 8 No. 358, Vedado, Havana, Cuba, General Secretary.

PAN AMERICAN MEDICAL ASSOCIATION, International Medical Cruise Congress, S. S. Nieuw Amsterdam, Jan. 6-22, 1954. Dr. Joseph J. Eller, 745 Fifth Avenue, New York 22, N. Y., U. S. A., Executive Director.

PAN-PACIFIC SURGICAL CONGRESS, Honolulu, Hawaii, Oct. 7-18, 1954. Dr. F. J. Pinkerton, Suite 7, Young Bldg., Honolulu 13, Hawaii, Director General.

ROYAL SANITARY INSTITUTE HEALTH CONGRESS, Scarborough, England, April 27-30, 1954. Mr. P. Arthur Wells, Royal Sanitary Institute, 90 Buckingham Palace Road, London S. W. 7, England, Secretary.

SECTIONAL MEETING, AMERICAN COLLEGE OF SURGEONS, London, England, May 17-19, 1954. Dr. Michael L. Mason, 40 East Erie St., Chicago 11, Ill., U. S. A., Secretary.

SOUTH AMERICAN CONGRESS OF ANGIOLOGY, Sao Paulo, Brazil, July 1954. For information write: Dr. Rubens Carlos Mayall, Rua Senador Vergueiro 73, Rio de Janeiro, Brazil, S. A.

WORLD CONGRESS OF CARDIOLOGY, Washington, D. C., and Bethesda, Md., U. S. A., Sept. 12-17, 1954. Dr. L. W. Gorham, 44 East 23d St., New York 10, N. Y., U. S. A., Secretary-General.

WORLD CONGRESS OF INTERNATIONAL SOCIETY FOR THE WELFARE OF CRIPPLES, Scheveningen-The Hague, Netherlands, Sept. 13-17, 1954. Secretariat: Miss H. P. Post, Pieter Lastmarkade 37, Amsterdam Z, Netherlands.

WORLD FEDERATION OF OCCUPATIONAL THERAPISTS, Edinburgh, Scotland, August 17, 1954.

WORLD MEDICAL ASSOCIATION, Rome, Italy, Sept. 26-Oct. 2, 1954. Dr. Louis H. Bauer, 345 East 46th St., New York 17, N. Y., U. S. A., Secretary-General.

DEATHS

Boland, Frank Kells ✠ Atlanta, Ga.; born in Indianapolis May 3, 1875; Atlanta College of Physicians and Surgeons, 1900; intern and later resident in surgery at St. Joseph's Hospital in Baltimore until 1903 when he returned to Atlanta to practice; joined the faculty of his alma mater, now Emory University School of Medicine, in 1903 as demonstrator of anatomy; professor of operative and clinical surgery when his alma mater was known as Atlanta School of Medicine, serving from 1905 to 1913 and professor of clinical surgery from 1913 to 1915; formerly professor of surgery and clinical surgery at Emory University School of Medicine, where from 1937 to 1946 he was a member of the board of trustees and at the time of his death was Joseph Brown Whitehead professor of surgery and chairman of the department; professor of anatomy at Emory University School of Dentistry from 1907 to 1919 and professor of physiology from 1919 to 1949; formerly vice-chairman, Section on Surgery, General and Abdominal, American Medical Association; past president of the Southern Medical Association, of which he served as chairman and secretary of the surgical section, vice-president, and chairman of the council; past president and vice-president of the Southern Surgical Association; past president and secretary-treasurer of the Chattahoochee Valley Medical Association; past president of the Atlanta Historical Society, Medical Association of Georgia, Fulton County Medical Society, Southeastern Surgical Congress, University of Georgia Alumni Society, which in 1940 awarded him a citation for distinguished service, and the Emory University Alumni Association; member of the American Surgical Association, American Association for the Surgery of Trauma, American Association for Thoracic Surgery, Société Internationale de Chirurgie, Chi Phi, Phi Beta Kappa, Phi Beta Kappa Associates, Phi Chi, and Omicron Delta Kappa; fellow of the American College of Surgeons; member of the founders group of the American Board of Surgery; during World War I was chief of the surgical service at Base Hospital 43, in Blois, France, where the Emory unit was stationed, and later was appointed colonel, Medical Officers Reserve Corps; chairman of the Atlanta chapter, American Red Cross, from 1938 to 1942; president of the Atlanta chapter, English Speaking Union, since 1942; president of the Crawford W. Long Memorial Association; consulting surgeon, Georgia Baptist Hospital; surgeon, Crawford W. Long Memorial, Grady Memorial, and Piedmont hospitals, St. Joseph's Infirmary, and Emory University Hospital; in 1926 was given the degree of doctor of science at the University of Georgia; on the editorial board of the *American Surgeon*; author of "The First Anesthetic: The Story of Crawford Long"; died Nov. 11, aged 78, of nephritis and uremia.

Thompson, Alvin ✠ Flint, Mich.; born in Racine, Wis., Dec. 12, 1880; College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, 1912; specialist certified by the American Board of Urology; member of the American Urological Association; past president of the Genesee County Medical Society and the Flint Academy of Surgery; at one time taught at Rush Medical College and Northwestern Dental School in Chicago, and was secretary-treasurer of the Chicago Urological Society; fellow of the American College of Surgeons; on the staffs of Hurley, St. Joseph, and McLaren hospitals; died Oct. 22, aged 72, of arteriosclerotic heart disease.

Menk, Paul Ernest ✠ Phoenix, Ariz.; Columbia University College of Physicians and Surgeons, New York, 1900; also a graduate in pharmacy; member of the Medical Society of New Jersey and the American Urological Association; specialist certified by the American Board of Urology; formerly practiced in Newark, N. J., where he was affiliated with Clara Maass Memorial Hospital, Babies' Hospital-Coit Memorial, Hospital of St. Barnabas and for Women and Children, Newark City Hospital, St. James Hospital, Irvington (N. J.) General Hospital, and Overlook Hospital in Summit; died Oct. 24, aged 76, of arteriosclerotic heart disease.

Sanford, Conley Hall ✠ Memphis, Tenn.; born in Dyer, Tenn., Sept. 12, 1893; University of Tennessee Coilege of Medicine, Memphis, 1918; interned at the Philadelphia General Hospital; served during World War I; specialist certified by the American Board of Internal Medicine; fellow of the American College of Physicians; since 1939 professor of medicine and chief of the division of medicine at his alma mater, from which he recently retired; recently retired as chief of staff at John Gaston Hospital; on the staff of the Baptist Memorial Hospital; died in Whitehaven Nov. 16, aged 60.

Abramson, Arthur Joseph ✠ San Francisco; University of California Medical School, San Francisco, 1937; served during World War II; died Oct. 27, aged 46, of myocardial infarction and arteriosclerosis.

Anderson, Charles Rhodes ✠ Winchester, Va.; University of Maryland School of Medicine, Baltimore, 1908; for many years member of the city council and mayor of Winchester; served during World War I; secretary of the Frederick County Board of Health; on the staff of Winchester Memorial Hospital; past president of the Chamber of Commerce; a director of the Commercial and Savings Bank; died Oct. 24, aged 75.

Barnes, Tiffany, Asheboro, N. C.; Medical College of Virginia, Richmond, 1925; member of the American Academy of General Practice; on the staff of Griffin Clinic-Hospital and Randolph Hospital; died Oct. 29, aged 55, of hemorrhage from esophageal varices.

Buckner, Frank Ingram ✠ Campbellsville, Ky.; University of Louisville Medical Department, 1913; county health officer; served as county coroner; formerly member of the city council and the city board of education; died in the Rosary Hospital Oct. 13, aged 65.

Burnett, Harry Webster ✠ Dayton, Ohio; Ohio State University College of Medicine, Columbus, 1915; specialist certified by the American Board of Radiology; member of the Radiological Society of North America and the American College of Radiology; on the consulting staff, Miami Valley Hospital, where he died Nov. 6, aged 61, of coronary disease.

Green, Edgar Vernon, Youngsville, N. C.; Emory University School of Medicine, Atlanta, 1937; affiliated with Franklin Memorial Hospital in Louisburg; died Oct. 14, aged 40, of injuries received in an automobile accident.

Green, Thaddeus Hall, St. Petersburg, Fla.; Atlanta Medical College, 1914; died Sept. 16, aged 63, of acute myocardial infarction.

Hanlon, Clement Richard ✠ Bethlehem, Pa.; Jefferson Medical College of Philadelphia, 1936; specialist certified by the American Board of Orthopaedic Surgery; member of the American Academy of Orthopaedic Surgeons; fellow of the American College of Surgeons; affiliated with Robert Packer Memorial Hospital in Sayre, Easton (Pa.) Hospital and St. Luke's Hospital; died Oct. 18, aged 43, of coronary occlusion.

Hardman, Charles Terrell ✠ Tallulah Falls, Ga.; Emory University School of Medicine, 1917; served as chairman of the board of trustees of the Tallulah Falls School and as physician for the Georgia Power Company; died in Emory University (Ga.) Hospital Oct. 4, aged 65, of rupture of aortic aneurysm.

Hartzell, Homer John ✠ Cleveland; University of Wooster Medical Department, Cleveland, 1902; held teaching appointments in the departments of chemistry and pharmacology at Western Reserve University School of Medicine, where, from 1919 to 1935, he taught ophthalmology; for many years consultant in eye diseases to the city public schools; at various periods on the staffs of old Lakeside Hospital and St. John's Hospital; died Nov. 1, aged 80, of carcinoma of the pancreas.

✠ Indicates Member of the American Medical Association.

V 1
195

Hendrickson, Harold Wesley ✠ Cedarville, N. J.; Hahnemann Medical College and Hospital of Philadelphia, 1940; served during World War II; affiliated with Bridgeton (N. J.) Hospital, where he died Oct. 25, aged 40, of coronary occlusion.

Hertel, Paul, Chicago; Bennett Medical College, Chicago, 1915; served during World War I; died in the Alexian Brothers' Hospital Nov. 18, aged 75, of peritonitis, pararectal abscess, and carcinoma of the rectum.

Hogan, Austin ✠ Johnstown, N. Y.; University and Bellevue Hospital Medical College, New York, 1902; died Aug. 26, aged 76, of cerebral hemorrhage and hypertensive cardiovascular disease.

Howell, John Valentine ✠ Marion, Ala.; Tulane University of Louisiana School of Medicine, New Orleans, 1921; died in the Perry County Hospital Aug. 20, aged 56, of acute coronary thrombosis.

Jackson, William Henry, Louisville, Ky.; Meharry Medical College, Nashville, Tenn., 1911; died Oct. 7, aged 68.

Jones, Zebulon Baird Vance, Norfolk, Va.; Jefferson Medical College of Philadelphia, 1920; at one time treasurer of the Berkley Machine Works and Foundry Company; treasurer of the Berkley Permanent Building and Loan Association; died Oct. 20, aged 58, of coronary thrombosis.

Kitson, Verner H., Elk Rapids, Mich.; Detroit College of Medicine, 1910; served during World War I; on the staff of the James Decker Munson Hospital in Traverse City, where he died Oct. 22, aged 66, of arteriosclerotic heart disease with coronary occlusion.

Koon, Alpheus Cary, Lakeland, Fla.; Lincoln Memorial University Medical Department, Knoxville, Tenn., 1916; died in the Morrell Memorial Hospital Sept. 19, aged 63, of cirrhosis of the liver.

McFarland, Arthur Sidney, Rolla, Mo.; St. Louis College of Physicians and Surgeons, 1906; died in the Phelps County Memorial Hospital Sept. 5, aged 80.

Mantooth, John Thomas ✠ Melissa, Texas; Chattanooga (Tenn.) Medical College, 1902; past president of the Collin County Medical Society; died in McKinney Aug. 10, aged 77, of complications following a prostatectomy.

Martin, Robert Clarence, Niagara Falls, N. Y.; University of Toronto Faculty of Medicine, Toronto, Canada, 1921; died Aug. 28, aged 60, of coronary occlusion.

Martin, Walter Evans ✠ Dallas, Texas; Baylor University College of Medicine, Dallas, 1931; member of the American Academy of General Practice; died Oct. 15, aged 56.

Mathisen, George B., Chicago; University of Minnesota College of Medicine and Surgery, Minneapolis, 1901; served during World War I; affiliated with Illinois Central Hospital, where he died Nov. 10, aged 78, of chronic glomerulonephritis and multiple myeloma.

Miller, Fred E., Lawrenceville, Ill.; Chicago College of Medicine and Surgery, 1916; died Aug. 24, aged 72.

Mitchell, Edward Dana, Sr. ✠ Memphis, Tenn.; University of Pennsylvania Department of Medicine, Philadelphia, 1898; fellow of the American College of Surgeons; past president of the Memphis and Shelby County Medical Society; affiliated with Crippled Children's Hospital School, St. Joseph Hospital, and Baptist Memorial Hospital, where he died Oct. 23, aged 77, of heart disease.

Moser, Oran Alexander ✠ Rocky Hill, Conn.; Yale University School of Medicine, New Haven, 1902; an Associate Fellow of the American Medical Association; past president of the Hartford County Medical Association; for many years health officer of Rocky Hill; formerly affiliated with the State of Connecticut Veterans Home and Hospital; vice-president and director of the Cromwell Savings Bank; died Nov. 10, aged 82.

Nesbit, Wellwood Mack ✠ Madison, Wis.; Rush Medical College, Chicago, 1917; professor of otolaryngology at University of Wisconsin Medical School; specialist certified by the American Board of Otolaryngology; member of the American Academy of Ophthalmology and Otolaryngology; affiliated with Madison General Hospital and State of Wisconsin General Hospital; died Oct. 27, aged 63, of coronary thrombosis.

Pasco, George William ✠ Wolcott, N. Y.; Syracuse University College of Medicine, 1934; past president of the Wayne County Medical Society; died Oct. 30, aged 46, of carcinoma of the liver.

Payne, Edward Albert, Woburn, Mass.; Tufts College Medical School, Boston, 1933; served during World War II; city physician; on the staff of the Choate Memorial Hospital, where he died Oct. 26, aged 43, of coronary disease.

Powell, John Wesley, Sisseton, S. D.; Kentucky School of Medicine, Louisville, 1901; died Sept. 15, aged 78, of nephritis, diabetes mellitus, and cardiac decompensation.

Price, Charles Richard ✠ Dayton, Ohio; Ohio State University College of Medicine, Columbus, 1930; on the courtesy staff of Miami Valley Hospital, where he died Oct. 23, aged 50, of cardiac arrest due to anesthesia and of mild cardiac hemorrhage due to contusion and multiple fractures of sternum, ribs, and mandible.

Reynolds, Jacob Thomas, Arcadia, Calif.; St. Louis College of Physicians and Surgeons, 1893; died Oct. 26, aged 82, of amyotrophic lateral sclerosis.

Roessly, George Rufus ✠ Cincinnati; Medical College of Ohio, Cincinnati, 1904; died in St. Mary's Hospital Nov. 8, aged 80.

Rush, William Madison, Fern Creek, Ky.; Hospital College of Medicine, Louisville, 1907; served during World War I; died Nov. 3, aged 82.

Schultze, Joseph Henry, Birmingham, Ala.; University of Louisville School of Medicine, 1934; served during World War II; member of the American Trudeau Society; died in Andalusia, Sept. 3, aged 47, of heart failure.

Schumacher, Cyril William ✠ St. Louis; St. Louis University School of Medicine, 1931; member of the American Academy of General Practice; affiliated with DePaul and St. Mary's hospitals; died Nov. 13, aged 46, of a skull fracture received in a fall.

Senescall, Cleve Ridlon ✠ Enumclaw, Wash.; University of Illinois College of Medicine, Chicago, 1915; served during World War I; died Oct. 21, aged 64, of coronary disease.

Shipley, John Thomas, Meyersdale, Pa.; Jefferson Medical College of Philadelphia, 1929; served during World War II; died Oct. 26, aged 50.

Siebert, Jacob ✠ Cleveland; University of Wooster Medical Department, Cleveland, 1907; died Oct. 28, aged 66.

Smith, Reuben Menifee ✠ Stearns, Ky.; Kentucky University Medical Department, Louisville, 1905; died Nov. 2, aged 78.

Thompson, Jesse Eugene, Bristolville, Ohio; Western Reserve University Medical Department, Cleveland, 1904; served during World War I; died Oct. 4, aged 77, of heart disease.

Wagner, Rudolf, Wayne, Mich.; Bennett Medical College, Chicago, 1910; died Oct. 30, aged 79, of hemorrhage into the abdominal cavity and dissecting aneurysm.

DIED WHILE IN MILITARY SERVICE

Coler, Eugene Seeley ✠ East Hampton, N. Y.; McGill University Faculty of Medicine, Montreal, Canada, 1922; associate clinical professor of obstetrics and gynecology at Columbia University College of Physicians and Surgeons in New York; specialist certified by the American Board of Obstetrics and Gynecology; fellow of the American College of Surgeons; affiliated with the Southampton (N. Y.) Hospital, Vanderbilt Clinic, and Sloane Hospital for Women in New York; served during World War II; Colonel (MC), U. S. Air Force Reserve; died in England Aug. 30, aged 57, of a heart attack.

FOREIGN LETTERS

BRAZIL

Esophagorespiratory Fistula.—A study on esophagorespiratory fistula was published by Drs. E. S. San Juan, Paulo Freitas, Iseu Costa, and Esmeralda Lomba in *Revista de medicina e cirurgia de São Paulo* (**13**:277 [June] 1953). The authors collected 42 cases of thoracic crushing injury including two cases of esophagorespiratory fistula. Such cases do not occur frequently, and their prognosis is poor. Dr. San Juan and coworkers described two cases. One patient was treated during the acute period by means of decompressive mediastinotomy and drainage of the pleural cavity. In spite of supplementary measures, the patient did not respond to treatment and died within 24 hours. The other patient survived the acute phase, the esophagotracheal fistula persisting for two months. The treatment used was suture of the esophagus and trachea after a right-sided thoracotomy.

The authors studied the symptoms and signs that appear in both acute and chronic phases, pointing out the difficulties in diagnosing the precise localization of the rupture of the respiratory passages—information necessary before surgical repair is attempted. When the patient does not die as a result of the accident, the lesion may be localized by means of bronchoscopy and esophagoscopy. Rupture of the trachea or of the principal bronchus always takes place in the membranous portion. A contrast examination of the esophagus should be made with iodized oil and controlled by radioscopy, with the patient lying face downward. Communication between the esophagus and the respiratory tract can be made evident in a simpler manner merely by oral administration of methylene blue. The dye will be immediately expelled by coughing if the patient is lying prone. Rupture of the trachea, bronchus, or esophagus, caused by thoracic crushing injury, must be treated without delay because the prognosis is grave. A decompressing mediastinotomy, drainage of the pleural cavity, and administration of oxygen diminish the dyspnea, cyanosis, and hypertensive pneumothorax. Generally, when these measures are taken, emphysema does not develop. Once the acute symptoms have disappeared, only the esophagorespiratory fistula remains. Some authors favor closing the esophageal-tracheal orifice by cauterization. Others, however, recommend surgical closure of the rupture of the esophagus and respiratory tract as the safer method.

Perforated Ulcers of Stomach and Duodenum.—In *Arquivos de cirurgia clinica e experimental*, Drs. Ruy Ferreira Santos, D. Bittencourt, Cassio Montenegro, Ary Carmo Russi, and C. Caricchio reported a study of 302 perforated gastric and duodenal ulcers seen in the emergency ward of the Hospital das Clínicas of the Medical School of the University of São Paulo during a seven year period. Duodenal perforations were more frequent (82.5%) than gastric perforations (17.5%). Eighty-one per cent of the patients were in the third, fourth, and fifth decades of life. The patients in their twenties predominated. Their ages ranged from 15 to 78 years (average 35.1). As a rule, the onset of duodenal ulcers and also perforation occurs at an earlier age than of gastric ulcers. There was a higher proportion of ulcers and their perforations in men than in women. Perforated ulcers occurred oftener during spring and autumn.

The percentage distribution of the perforations through the 24 hours of the day showed that the duodenal ulcers perforated oftener in the morning, before breakfast, and that the gastric ulcers are more apt to perforate in the evening and during the night, in the periods of digestive activity. Only 10.6% of the patients had not had epigastric pain, pyrosis, nausea, or vomiting in the past. Bleeding and other digestive symptoms were reported less frequently.

In this series the preponderant symptom of perforation was a sudden sharp pain in the epigastrium, radiating to the lower right abdominal quadrant or to the right shoulder. Reflex vomiting was common. Peritoneal irritation was manifested in 93% of the patients by rigidity of the abdominal wall. Paralytic ileus was rare, probably because of the early admission to the hospital. Six per cent of the patients came to the hospital later and had severe peritonitis with meteorism, a dull percussion note in the flanks, and bulging of the pouch of Douglas. The liver dulness disappeared in 62%. Since the roentgenological examination at various angles revealed free gas in the peritoneal cavity in only 77%, the absence of roentgenological signs of pneumoperitoneum does not rule out a perforated ulcer and, in such a case, the diagnosis must depend chiefly on the history and physical findings. Absence of pneumoperitoneum does not always mean there is a sealed perforation, but this diagnosis is very likely when there is free gas in the peritoneal cavity and improvement of the abdominal rigidity. Hydropneumoperitoneum indicates diffuse and severe peritonitis. Deterioration of the general condition of the patient was more frequently observed in the patients with gastric than in those with duodenal perforation.

The mean elapsed time from the moment of perforation until admission to the hospital was 11.4 hours. A wrong diagnosis was made 13 times, consisting of acute appendicitis in 11 patients, acute cholecystitis in one and acute abdominal condition, cause undetermined, in one.

Suturing operations were performed in 47 patients in this series, including simple suturing in 20, suturing plus epiploplasty in 23, suturing plus gastroenterostomy in 3, and suturing after selective resection of the ulcer in one. Resections were performed in 252 patients; the anastomosis was antecolic in 167 and retrocolic in the rest. The authors prefer gastroduodenal resection because: (1) the suturing operations are not always curative, and in many patients the ulcer persists and a second operation must be performed (40 to 65% according to the literature; 22.7% in this series); (2) resection prevents recurring perforations (only one recurred in this series); (3) resection eliminates the possibility of multiple ulcers and the danger of not recognizing multiple simultaneous perforations (one patient in this series had multiple perforations); (4) resection prevents a stenosis and postoperative bleeding and takes into consideration the possibility of the perforation being associated with a gastric malignancy; and (5) the operative mortality following resection is low.

The criterion for selecting the palliative or the radical operation is the evaluation of the patient's age, the elapsed time after the perforation, the patient's general condition, and the peritoneal reaction observed during laparotomy. Drainage was used in 20 of the resections to prevent or treat diffuse peritonitis. It was indicated when the general condition of the patient or some technical accident led to fear of an eventual leakage around the sutures. Inhalation anesthesia or subarachnoidal spinal anesthesia was used, according to the preference of the surgical teams. As a rule, spinal anesthesia was not used when the general condition of the patient was poor or when too many hours had elapsed since the perforation.

The duration of hospitalization of the surviving cases was taken as a quantitative index of the complications. It appeared to depend on the elapsed time between perforation and treatment and on the patient's age rather than on the duration of the operation. On the average, the patients with gastric perforation, those treated by palliative suturing, those in whom drainage was necessary, and those who were given inhalation anesthesia remained in the hospital for longer periods, but it must be remembered that, as a rule, all such patients were

The items in these letters are contributed by regular correspondents in the various foreign countries.

V 1
195

admitted in poor general condition. Postoperative complications developed in 49 patients.

Further treatment, including radical surgery, was needed in 22.7% of the surviving patients treated by suturing and who answered a follow-up questionnaire. Although the follow-up studies are not complete, the patients treated by resection were cured. A few patients had mild sequelae following gastrectomy.

Intestinal Schistosomiasis as an Occupational Disease.—Dr. Samuel Pessoa, São Paulo State University, reported to the Associação Paulista de Medicina a study on 18 patients with intestinal schistosomiasis among employees of the National Malaria Service who clean the sanitation ditches at Aracajú, Sergipe, without wearing boots. Under these conditions, they are subjected to continuous heavy infestations by cercariae of Schistosoma mansoni. These workers have very high incidences of allergic and toxic phenomena and cirrhosis, anemia, a high erythrocyte sedimentation rate, and eosinophilia are more marked in them than in other victims living in the vicinity. Bronchial manifestations are observed in the severer cases; they are frequently diagnosed as bronchitis and are due to the direct effect of the parasites or to circulatory alterations. The author pointed out that the high sedimentation rates are probably due to hepatic lesions, and he believes the fever, present in severer and older cases of the disease, to be caused by an allergic mechanism.

CHILE

Seventh Medicosurgical Meeting of Valparaiso.—The transactions of the seventh medicosurgical meeting of Valparaiso appeared in the March issue of the quarterly of the Valparaiso Medical Association. Leukemia, primary cancer of the lung, and antibiotics were discussed.

Leukemia.—Dr. Etcheverry stated that there are three approaches to the pathogenesis of leukemia: the infectious, the neoplastic, and the one that considers leukemia a disease of adaptation. After analyzing each of these, the author inclined to the belief that the leukemic cell, because of its immaturity and malignant character, has much in common with the neoplastic cell. The symptoms and clinical course were described by Dr. Raul Cabrera. In a series of patients with acute myeoblastic leukemia, 40% had splenomegaly and 70% had hepatomegaly. Involvement of the lymph glands was noted in 34%, and in 81% of these the involvement was limited to the cervical nodes. Pallor of the skin and mucosa was present in all the patients and was parallel with the degree and with the evolution of the anemia. Leukamid was present in 12%. Nearly 40% had temperatures that fluctuated between 99.5 F and 101.3 F, and 21% had temperatures between 102.2 F and 104 F. Purpuric manifestations were present in 46%, epistaxis in 59%, pyorrhea in 59%, and metrorrhagia in 15%. Palpitation on exertion was common, and a soft systolic murmur at the apex was present in 4% of the patients. Respiratory symptoms were rare. Anorexia or diarrhea or both occurred in 25%, arthralgias in 15%, and neurological signs in 28%. In a series of patients with acute lymphoblastic leukemia, splenomegaly was present in 83% and hepatomegaly in 40%. The lymphatic system was frequently involved. Pallor of the skin and mucosa was present in all the patients, and 87% had a febrile course.

In a group of patients with chronic myeloid leukemia, splenomegaly was present in 60% and hepatomegaly in 95%. Hemorrhages occurred in 4.6%. Although lymph glands were frequently involved, myeloid metaplasia was present in only 7.6%. Pallor of the skin was present in 85%, moderate fever in 61%, and neurological signs in 10%. In a series of patients with chronic lymphatic leukemia, splenomegaly was present in all the patients and hepatomegaly in 76%. A moderate irregular fever was noted in 28%.

Dr. Garreton and associates discussed the incidence of leukemia in Chile, which in the hospital population varies between 0.22 per thousand and 0.38 per thousand. An increase in prevalence was noted between 1940 and 1947. In children 94% of the cases were of acute leukemia. The chronic type is observed much more frequently in men than in women. The death rate from leukemia was 0.33 per thousand in 1940 and 1.05 per thousand in 1951.

Cancer of the Lung.—Drs. H. Apablaza and C. Palma reviewed 6,161 autopsies performed in the Van Buren hospital of Valparaiso between 1936 and 1951 and found that primary cancer of the lung was second in frequency only to cancer of the stomach. The right lung was more frequently the site of neoplasm than the left. Dr. Olivares and co-workers of the Salvador Hospital of Santiago reviewed 21,642 hospital admissions between 1942 and 1949 and found that, of all cancers, gastric neoplasms accounted for 48%; cancer of the esophagus for 8%; cancer of the biliary tract for 6%; and primary cancer of the lung for only 3%. Dr. Fritis and co-workers presented statistics showing that 60% of the primary cancers of the lung were of the undifferentiated type; 20% were of the epidermoid type; 14% were adenocarcinomas; and 3% were of the alveolar type.

The value of signs and symptoms in the diagnosis of cancer of the lung was discussed by Dr. Lucchini and associates. They concluded that most patients come to the physicians too late, mainly because the symptoms in the beginning are vague and not severe. Dr. Salvestrini and co-workers spoke of the use of radiology in the diagnosis of cancer of the lung. In all of the 105 cases described, radiological signs of cancer were present, but the interpretation was erroneous in 80 cases. This high percentage of error is due mainly to the fact that the cancer gave direct radiological evidence of a small tumor in only 26, whereas only indirect signs were present in 79 patients. Dr. H. Dew of Australia stated that in his country the radiologist makes the diagnosis in 30% of the cases. The main value of the roentgenogram is that it is often the source of our first suspicion of cancer of the lung. If every patient with a thickened shadow in the center of the lung is considered to have cancer until it is proved otherwise, the percentage of positive diagnoses should greatly increase.

Dr. G. Zamorano and associates of Valparaiso obtained negative results from bronchoscopy in 42% of the patients with cancer of the lung in whom bronchoscopy was performed, but they maintain that nevertheless this simple technique should always be used in patients suspected of having cancer of the lung. Dr. H. Dew of Australia stressed the fact that the use of bronchoscopy, roentgenograms, and biopsies can give a positive diagnosis in almost 80% of all cases.

Dr. R. Eulufi presented statistics on cytological diagnosis. In 41 patients with proved cancer of the lung, neoplastic cells were found in only 6, and he concluded that the value of this method is great when the findings are positive but that negative findings are valid only if they are repeated five or six times.

Antibiotics.—Dr. A. Vargas Carretero and associates observed 94 patients (73 of whom died) with subacute endocarditis between January, 1947, and June, 1952. The average age of the patients who survived was 27.4 years and of those who died 41.2 years. Of those who died, 37 received no antibiotic treatment, because the diagnosis was not made and the remaining 36 died during the treatment. The authors stressed that a favorable result can be expected in 54% of the patients if the treatment is started early and in only 25% if the treatment is started later than three months after the onset. Of 56 patients who were not treated with antibiotics because a correct diagnosis was not made, 93% died within six months and the rest within one year. Of a group who were treated with antibiotics, 77% died within six months and 3.8% survived for more than two years. Anatomical changes are another means of studying the effects of antibiotic treatment. The heart valves of patients who had been treated but had died of subacute endocarditis showed at autopsy various degrees of healing. The average spleen weight in patients without treatment was 324 gm., and in those who had a full course of treatment 272 gm. Another important finding was that well-conducted treatment prevents nephritis.

Antiparasite Campaigns in Chile.—Prophylactic activities against hydatidosis have continued in the province of Valdivia. A. Hube found Taenia echinococcus in 19 of 434 dogs. A total of 4,012 dogs were given arecoline hydrobromide. This was accompanied by an educational campaign in 43 schools. Movies dealing with hydatidosis were shown to more than 30,000 persons in small villages. More than 6,000 people were treated between February and May, 1953. In the period of January to March, the staff of the department of parasitology examined 2,691 persons in Lanco, Malalhue, and Panguipulli. Of 2,166 Ghedini-Weimber reactions, 70 were positive, and, of the same number of Casoni intradermal reactions, 169 were positive. The new reaction of conditional hemolysis, which was first used in Chile by Negme, Naquira, and Tagle, was performed on 2,186 persons and was positive in 133. A mobile x-ray unit permitted the study of pulmonary hydatidosis. In order to evaluate the results of the educational campaign, a survey was conducted in Malahue that revealed that 80% of the population knew how to dispose of the organs of cattle with hydatidosis, whereas prior to the campaign 90% of the population did not know.

After the diagnosis of the first acute cases of American trypanosomiasis (Chagas' disease) made by Drs. G. Gasic, R. Gajardo, and A. Neghme of the department of parasitology, a survey of all the country was started to determine the importance of infection by Trypanosoma cruzi. With this in mind, the department undertook to define the endemic areas, and in these areas infestation with Triatoma infestans was studied. The xenodiagnostic method was used to determine infection by T. cruzi. Since 1944 a total of 25,919 xenodiagnoses were made on persons living in endemic zones, with positive results in 8.7%. In addition to this, 6,256 domestic animals were examined and 8.1% were found to be infected. Most persons infected with T. cruzi were asymptomatic carriers; others had myocarditis.

Availability of Food in Chile.—The department of foodstuffs of the National Health Service has for the last 15 years been making a survey of availability in order to determine the exact state of the diet of the population. Drs. A. Riquelme and M. Garcia B. have recently completed a report on this subject covering the years 1947-1951. The average per capita distribution of foodstuffs was calculated by adding to the national production all imported foodstuffs and subtracting that which was exported. The population of the country was fixed at 6 million according to the latest census. As compared to the per capita per year figures for 1926 (based on the population of Santiago only), the milk supply increased from 36 to 102 liters; fish and other sea foods from 8 to 10.3 kg.; citrus fruits from 4.5 (in 1941) to 9.2 kg.; vegetables from 18.25 to 60 kg.; and sugar from 20 to 28 kg. There was no change in the figures for eggs (37.4), potatoes (75 kg.), and cereals (170 kg.). The figures for meat dropped from 73 to 31 kg.; for legumes from 15.3 to 6.6 kg. (mainly due to an increase in export); and for fats from 14.6 to 6.4 kg.

At the fifth annual meeting of the Chilean Society of Nutrition, Dietetics, and Toxicology held in December, 1948, a list of foodstuffs was drawn up that was to be the goal that must be attained in the nutritional plan of the country. Expressing the results in percentages of deficit or overproduction, the report noted a deficit of 70% for meat; 65% for legumes; 42% for potatoes; 46% for other vegetables; 65% for eggs; 49% for citrus fruits; 42% for fats; 33% for milk; and 14% for fish and other sea foods. There was an excess of 86% for sugar; 20% for cereals; and 6% for other than citrus fruits. The report further compares the nutritional values in the chart that they obtained with the one recommended by the National Research Council of the United States and obtained the following figures (expressed in percentage of deficit): for calcium, 52%; for riboflavin, 45%; for thiamine, 37%; for niacin, 36%; for caloric value, 30%; for ascorbic acid, 28.4%; for iron, 27%; for vitamin A, 10%; and for proteins, 14.3%. In conclusion means for remedying the situation, on both a short and long term basis, were proposed.

LONDON

Smog.—The smog that devastated London last December continues to be a subject of topical interest. Everyone has his remedy for it, and investigations are being carried out at all levels from the government downward. In the medical sphere it has been responsible for an interesting tiff between the general practitioners of London and the Ministry of Health, in which the Ministry has come off best. Toward the end of October the local Medical Committee for the County of London, a statutory body set up under the National Health Service to represent the 6,000 physicians in Greater London, issued a statement to the press calling for immediate action by the government to prevent a repetition of the disaster, and advising the wearing of gauze masks, comparable to those worn by surgeons, should there be a recurrence. The results were a rush on pharmacies the next day for gauze to make homemade masks—at a time when there was a shortage of gauze in the country—and an official statement from the Ministry of Health.

This was a carefully reasoned statement pointing out that there was some danger that the public might take the suggestion as being too easy a solution, and indicating that it was necessary to distinguish between ordinary persons who are not ill and those suffering from weakness of the heart and lungs. In the case of the former a simple gauze mask might help, but such a mask has certain obvious difficulties, since it is intended primarily to prevent spray from going outwards from the mouth and nose and not to prevent the intake of noxious substances. The statement went on to point out that there are simple masks widely used in industry that are more effective than the surgeon's gauze mask and are available commercially at little cost. Other practical measures are probably quite as effective as the surgeon's gauze mask and can be produced in the home, such as a scarf or towel or other cloth worn round the face. In the case of patients with pulmonary or cardiac disease, the problems are much more difficult, as the more efficient the mask the more difficult would it make the breathing. Such patients should be advised to stay at home during a thick fog, since fog is always less dense indoors than out. The statement added that the Ministry was actively investigating the problem.

The results of its activities have now been announced by the Minister of Health as follows: "I am advised that . . . no mask which people could be expected to wear for long periods is likely to give complete protection, but that there are certain types of masks which may give some help to those most likely to be affected by smoke-polluted fog—namely people suffering from existing disease of the heart or lungs. I am, therefore, proposing to enable doctors, if they feel it to be desirable in each individual case, to prescribe under the National Health Service certain specified types of masks for patients suffering from these conditions who live or work in an area where smoke-polluted fog is likely to occur." Two types of masks are to be made available: one with a semirigid frame capable of being molded to the face and one fastened by tapes, of a type usually worn by surgeons. Both will incorporate removable pads of thin gauze and cotton tissue.

Thus ends an episode that should show the general practitioners the dangers of unskilled public relations. A little more contact with the Ministry of Health might have saved them a great deal of discomfiture. An editorial in *Lancet* (2:976 [Nov. 7] 1953) stated, "A gauze mask or a woollen scarf could be expected to exclude a reasonable proportion—perhaps a half to three-quarters of the particles, which might be enough to bring the pollution of inhaled air below the margin of danger. Complete purification is . . . too much to hope for. The more layers of gauze used, the more efficient the mask will be; but a balance will have to be struck between efficiency and resistance to breathing. The scarf or mask will serve a second purpose, warming and humidifying the incoming air . . . A gauze mask or, possibly better, a thick woollen scarf wrapped round the face, by excluding droplets and by warming and scrubbing the inhaled air, may, so far as can be judged, really prove useful. The only . . . danger seems to be too great a respiratory resistance in a patient already breathing with difficulty. Possibly, . . . warming the air is as important as filter-

ing it. A bronchitic's room should . . . be well heated, even if he cannot wear a mask; . . . the method of heating should not entail sucking in more fog from outside; electric radiators are particularly suitable."

BCG Vaccination.—In 1949, official permission for the use of BCG vaccine was first given in this country for nurses and medical staffs in hospitals and (at the discretion of chest physicians) for the close home contacts of tuberculous patients. The Medical Research Council is also carrying out an extensive controlled trial among persons leaving school. The Minister of Health has now announced that he is prepared to approve plans for giving BCG vaccination to children before they leave school. Vaccination should be carried out by designated medical officers on the responsibility of the medical officer of health. It is to be given to children during and, if possible, toward the end of the year preceding their 14th birthday. This means that the child will be at school for at least another year before leaving and will therefore be under supervision. Parental permission must be obtained in writing before vaccination.

This announcement has come as a surprise to many, in view of the conservative attitude of the Ministry of Health's advisors on the subject. Cause for such surprise is, however, greatly diminished on reading the accompanying memorandum on the subject, which so damns the process with faint praise that he will be a brave medical officer of health who will take advantage of this new dispensation. As typical of the official attitude of Great Britain on BCG vaccination, a few extracts from this memorandum may be of interest. It starts off with the dogmatic statement that despite the vast number of vaccinations that have been performed with either liquid or lyophilized vaccine during the past 20 years, there is no scientific evidence of its value. On the other hand, it is conceded that "from the work that has already been done on the vaccine it can be generally assumed that the preparation, in the doses usually prescribed, is harmless. It may also be reasonably accepted from trials abroad that the vaccine confers some degree of protection against the first infection with virulent M. tuberculosis. It is, therefore, probable that vaccination will lower the incidence of active primary tuberculosis in its various clinical manifestations, in particular, such forms as meningitis, miliary tuberculosis and primary tuberculous pleurisy. There is much less conclusive evidence that vaccination protects against subsequent super- or reinfection, although there are observers who believe that the development of postprimary tuberculosis is rendered less severe by inoculation. There is no absolute scientific proof in countries where the vaccine has been extensively used over many years that the fall in the tuberculosis mortality figures is due to BCG. In a number of countries where no BCG has been used there has been an equally rapid decrease in the number of deaths from tuberculosis. There are some who claim that BCG vaccination confers no benefit upon the individual and that all the apparent improvement in the incidence and mortality figures following mass vaccination is due to the collateral influence of other factors, such as the increased medical observation and improved living conditions and selective sampling. It is possible that those vaccinated are already a selected group, as an unknown number of the positive reactors of the population has already developed active disease. The most susceptible have therefore already been removed from the material under survey."

It is considered "unwise at this stage to extend the scheme generally to newborn infants: first, because it is in many instances unnecessary; secondly, because BCG vaccination removes completely the value of the tuberculin test in diagnosis; thirdly, because in the absence of subsequent infection the post-vaccination tuberculin sensitivity tends to wane and eventually disappear so that re-testing at frequent periods is necessary, and fourthly, because the complication rate is higher in newborn infants than in the older age groups, probably due to the greater difficulty in performing the intradermal injection and the slow development of the defensive mechanism."

It is recommended that two prevaccination intradermal tuberculin tests should be carried out, using purified protein derivative (Seibert), 0.00002 mg. (0.1 ml. of tuberculin) and 0.0002 mg. (0.2 ml. of tuberculin). The liquid vaccine is obtained from the State Serum Institute, Copenhagen. For some reason it is not made in this country. As the National Association for the Prevention of Tuberculosis points out in its annual report, "This seems astonishing when it is realized that the vaccine is produced in Canada, the U. S. A., India, Ceylon, Australia, Singapore, Indonesia, Turkey, China, Japan, three South American countries, the U. S. S. R., and at least ten European countries."

Vaccination is to be carried out by strictly intradermal injection. As a general rule, segregation of school children is not considered necessary, except when the child is living in close contact with a person with infectious tuberculosis. There is considered to be no need to make roentgenograms of vaccinated children routinely unless complications develop. Constitutional reactions are stated to be extremely rare, and the incidence of local reactions is put at 0.3%.

Plea for Decentralization of Hospital Control.—In a memorandum prepared for the Hospital Discussion Group by a working party of hospital administrators and published in *Lancet* (**2**: 1035, 1953), a plea is made for increased decentralization in the control of hospitals under the National Health Service. As an example of the present excessive degree of decentralization, attention is drawn to the fact that between July, 1948, and the end of 1952, the total number of circulars issued by the Ministry of Health was 656 to regional hospital boards, 583 to hospital management committees, and 598 to boards of governors of teaching hospitals. This is about one circular every three days to every hospital in the country. As the memorandum comments: "Few will deny that 'The formulation of policy in its major features' is the proper function of the Ministry, but is it essential for the Ministry (as opposed to a regional board or management committee) to issue detailed guidance on such matters as supply of razorblades to patients, issue of sweets to children, provision of telephones for hospital staff, washing-down of walls and paintwork, and detailed control of establishments? Complete standardization on such matters, and on many others, makes for administrative convenience and tidiness at the expense of individual judgment, initiative, and responsibility. Detailed control and advices on these aspects of hospital life could safely and more satisfactorily be left to the individual authorities or their officers."

In the financial field, centralized control in its present form is considered "generally reasonable," but a plea is made for a system of five-year grants for building maintenance and capital expenditure. Strong exception is taken to the attempted application of civil service methods to hospital administration. "What appears to cause both difficulty and antagonism at the present time is the tendency for the Civil Servant to apply to every level of the hospital service the methods of impersonal administration that are suitable for the central functions of the Ministry, but not for the day-to-day management of individual hospitals or hospital groups." An appeal is also made for a greater degree of delegation of power from the regional hospital boards to hospital management committees. There must be a certain amount of central control by the regional boards, but "it should be the policy to give to the management committees as much freedom as possible and to avoid interference in the details of day-to-day administration."

Tuberculosis in Scotland.—A depressing picture of the prevalence of tuberculosis in Scotland is given in the 39th annual report (1952-53) of the Royal Victoria Hospital Tuberlosis Trust for the Care and Prevention of Tuberculosis throughout Scotland. The mortality figures as a whole are favorable. In 1952 the death rate from respiratory tuberculosis was 27 per 100,000 of the population, and from nonrespiratory tuberculosis 5 per 100,000, giving a mortality from all forms of the disease of 32 per 100,000, which is the lowest figure on record. Nevertheless "there is a much more sinister side to the problem of respiratory tuberculosis." The death rate from tuberculosis of the lungs in young men from 15 to 24 is half as much again as it is in England, and the mortality among young women in this age-group is twice as high. The position in relation to new cases is also very disquieting. The provisional figure for cases of respiratory tuberculosis reported in 1952 was 7,259, compared with 7,776 in 1951 and 8,653 in 1949. The annual

number of notifications, though falling, is still over 60% higher than it was in 1936. Half of the new cases are among young persons. The situation is even worse than the provisional figures suggest, because in 1936, only 74% of the notifications were subsequently confirmed, whereas in 1951, 97% were confirmed. It is estimated that the increase in new cases between 1936 and 1951 is about 110%. The contribution of cases found by mass miniature radiography to this increase is considered to be insignificant compared with the number found in routine medical practice.

"The Committee, therefore, wish to state again with all the emphasis they can command that the publicising each year of overall death-rate figure which is stated to be yet another low record for tuberculosis does a public disservice, since it creates in the mind of the people the erroneous impression that tuberculosis is 'on the run.' The information that the annual number of confirmed new cases and the total number of known sufferers are over twice what they were before the war receives less publicity. The fact that in Scotland the statistics are worse than in most countries of Europe from which reliable figures are available is little appreciated."

Actinomycosis in Scotland.—According to I. A. Porter (*Brit. M. J.* **2**:1084, 1953) a survey of hospital records revealed the occurrence of 186 cases of actinomycosis in Scotland during the 13 years from 1936 to 1948. A total of 98 patients came from the northeast of Scotland, which is predominantly agricultural and has a population of 444,000. The remaining 88 patients came from the rest of Scotland, which has a population of 4,398,000. There was no significant difference in the rate of attack between residents in the large towns and residents in the small towns and rural areas in the northeast area, but in the rest of the country there was a significantly higher attack rate in the smaller towns and rural areas than in the large towns. Of the 173 patients whose occupations were known, 39 were in agriculture—a higher incidence than that of any other occupation. The ratio per 100,000 for male agricultural workers was 146 in the northeast area, 29 in the rest of the country, and 50 for the entire country. The comparable figures for nonagricultural workers were 33, 3.3, and 5.2. Just over half the cases (94) were in the 10 to 29 age-group, and 78% of the patients were male. The cervicofacial region was most commonly affected (65%), followed by the abdominal region (19%). In 22 instances the disease appeared in the cervicofacial region following dental extraction, and in another 33 patients carious teeth were noted. In 23 of the abdominal cases there was a history of an associated appendectomy, and in two of an appendiceal abscess.

Hospital Independence.—Mr. Macleod, Minister of Health, announced that he has asked the committee inquiring into the cost of the National Health Service to consider a new method of financing state hospitals. The method is a block grant system similar to that used for universities. If such a change were approved by Parliament, hospitals would gain much in independence and freedom. At present yearly estimates must be sent to the Ministry of Health, which can and does reduce them. Any unspent balance at the end of the fiscal year may not be carried forward. This form of financing, with ultimate control vested in the Ministry, imposes a rigid pattern on hospital planning and expenditure.

If block grants covering a number of years, made by a body resembling the University Grants Committee, were substituted, hospitals would be freed of direct government interference. They would also enjoy more latitude in planning and incurring expenditure. Mr. Macleod, in making his announcement, confessed that he had not made up his mind on methods of financing.

New Cancer Research Laboratories.—The Imperial Cancer Research Fund was founded in 1902, under the direction of the Royal College of Physicians of London and the Royal College of Surgeons of England. It was one of the first organizations to undertake experimental research in its own laboratories. It first occupied rooms in the Royal College of Surgeons. Its scope and activities gradually extended until, in 1939, a block of modern laboratories was built and opened at Mill Hill on the northern side of London. In 1951, the council of the fund decided to foster and support special investigations on outstanding problems of cancer in human pathology. Since the subjects chosen for investigation were closely related to the surgical treatment of human cancer, it was decided that this work should be begun in the pathology department of the Royal College of Surgeons. Under the direction of Prof. G. Hadfield, the work expanded rapidly, and additional space was provided by renting from the Royal College of Surgeons the house at no. 48, Lincoln's Inn Fields. The new laboratories were officially opened on Nov. 10 by Prof. H. R. Dean of Cambridge, the dean of English pathology and chairman of the council of the fund. The work will be integrated with the experimental work done at the Mill Hill laboratories under the direction of Dr. James Craigie and with observations made on clinical material from the London teaching hospitals.

MEXICO

Leprosy in Mexico.—Although not comparable in importance to tuberculosis and malaria, leprosy is still a public health problem in Mexico. For that reason the Department of Public Health and Assistance has a special organization to fight this disease, called the National Campaign Against Leprosy. Some of its activities, as well as other facts concerning leprosy in Mexico, were pointed out recently by Dr. Roberto Núñez Andrade, in the *Gaceta Médica de México* (**83**:5, 1953).

Before the arrival of Spanish conquerors leprosy did not exist in Mexico. It is likely that it was brought in by the conquerors and by African and Antillean Negro slaves in the early part of the 16th century, when it first was recognized in the Yucatán península. Travelers from the Philippine Islands, Japan, and China spread leprosy along the Pacific coast.

The number of patients with leprosy officially registered at the National Campaign Against Leprosy offices up to Dec. 31, 1952, was 11,087. The highest leprosy rate is found in the state of Colima, with 310.8 patients per 100,000 population. The rate for Mexico as a whole is 40.7 per 100,000.

Many regions in the country have not been intensively surveyed yet, and there is sometimes a disinclination to give information to health officers. It is conceivable that there are over 50,000 persons with leprosy in Mexico. About 66% have the lepromatous type; about 20% the tuberculoid; and the type of the remaining 14% is undetermined. Ninety per cent of the patients are adults. The disease is rare in persons of pure white or pure Indian blood; 98% of persons with leprosy are "mestizos." Almost 100% of the patients are classed as poor. Most of the registered male patients are farmers, city workers, or clerks, and most of the female patients are engaged in housework.

The National Campaign Against Leprosy has a leprosarium, 4 special wards in general hospitals, and 19 dispensaries for treating the disease. Through these facilities it has been possible to isolate 3.6% of the patients in the leprosarium and 1.3% in the wards. Specific treatment with the sulfones has been carried out in 13.7% of the patients, and 0.06% have been released at its completion. Private contribution has added three segregation homes, which house about 60 healthy children separated from their parents since birth. There is still a high death rate among the patients from such causes as generalized dissemination of the disease, cachexia, enterocolitis, lobar pneumonia, nephritis, cardiac insufficiency, pulmonary tuberculosis, edema of larynx, and cancer.

National Congress for the Protection of Children.—The first National Congress for the Protection of Children was held at Mexico City, Aug. 9 to 15. It was organized by the Department of Public Health and Assistance and sponsored by the President of the Republic. The main purpose of the congress was to draft a federal code for the protection of children. The present status of the law protecting children in Mexico, children's social medical care, educational protection, child labor, and the care of disabled children were among the problems discussed.

SWEDEN

Intoxicated Motorists and Pedestrians.—In 1949 a government committee was appointed to investigate the part alcohol plays in causing traffic accidents. The committee undertook a statistical study of the persons convicted of driving under the influence of alcohol between July 1, 1948, and June 30, 1949. Much other material was studied, and recommendations were made with a view to reducing such accidents. These recommendations reflect the committee's desire to tighten up already existing regulations. It was argued that the concentration of alcohol in the blood should be investigated not only in motorists but also in bicyclists, drivers of horse-drawn vehicles, railway engines, trams, ships, and airplanes, and other persons dealing with such vehicles. A concentration of alcohol in the blood as low as 0.05% should count in weighing evidence against suspects, and the police should have the right to test a driver's sobriety by measuring his expired breath by means of the so-called drunkometer.

Having been invited to comment on the recommendations of this committee, the Swedish Medical Association expressed grave doubts regarding the 0.05% level of blood alcohol, for it is doubtful if what is called the criminalization of persons showing this level will contribute to greater traffic security. In view of the American investigations (Holcomb's) and other observations, the level should be raised to 0.1%; on the other hand, it would be well for responsibility for traffic accidents to be extended to the pedestrian whose consumption of alcohol may have contributed to them. All persons involved in traffic accidents, including the driver of a push bicycle, should come under the same law in respect to alcohol consumption. Use of the drunkometer by the police should not be extended to an attempted estimate of the degree of the effect of alcohol but should be limited to determining the presence or absence of alcohol in the breath. The Swedish Medical Association also recommends further study of the factors contributing to traffic accidents.

Legal Abortion Statistics.—The government committee appointed in 1950 to study the problems of abortion, legal and illegal, issued a memorandum on the subject in September. In his comments on this memorandum in the organ of the Swedish Medical Association, *Svenska Läkartidningen*, Dr. Gunnar Berg quotes some impressive figures. The new law of 1938 concerned with legal abortions was not reflected in a marked rise of their number till 1943, when they numbered 703. There was a marked rise in the following years, and it culminated in 1951 with 6,328 or 58 legal abortions per 1,000 parturients. This number fell to 5,322 in 1952, and the figure for the first quarter of 1953 was smaller than that for the first quarter of 1952. This fall appears to reflect an increased tendency on the part of the medical authorities to reject applications for legal abortion, for in 1949 only about 13% of these applications were rejected, whereas the corresponding figure for 1951 was about 16% and for 1952 about 21%. In the same period there has been a fall in the total number of applications, from 6,884 in 1951 to 6,201 in 1952. Spontaneous or illegal abortion occurred among 21.9% of the 759 women whose applications for legal abortion in 1947 and 1949 were refused.

It is remarkable how greatly the indications for legal abortion have varied between 1940 and 1950. In 1940 as great a proportion as 71.9% of the indications for legal abortion was disease or some bodily ailment, while the corresponding figure for 1950 was down to 30.2%. Eugenic indications fell from 23.7 to 9.2% in the same period and humanitarian indications from 1 to 0.3%. On the other hand, weakness or general debility was an indication for legal abortion in only 3.4% of the applicants in 1940, whereas the corresponding figure for 1950 was 50.7%. Certain general principles seem, however, to be gaining general credence, and in the above-mentioned memorandum there is a recommendation for the obligatory adoption of sex education in all the schools and free medical advice on contraception. It is noted that knowledge of the qualitative merits of contraceptives has not advanced in pace with the gains made by medical research in other fields. The public authorities, therefore, would do well to provide the means for further scientific research concerning contraceptives.

The Prognosis for Lobotomy.—At the Lillhagen Hospital, Gothenburg, lobotomy has been undertaken on so many patients since 1946 that it is now possible to calculate approximately the ultimate prognosis for the patients operated on. In 1951, Dr. Sven Foltmann published a preliminary report on the first 100 women patients operated on between 1946 and 1950. In *Nordisk Medicin* for Oct. 15, 1953, he has brought his figures up to date and has shown how necessary it is to allow an observation period of some years before evaluating the final results. After withdrawing 3 cases for various reasons, he follows the fate of the remaining 97 bilateral cases, 55 of which were operated on according to the Freeman and Watt technique and 42 according to the Lyerlys technique. There were 71 cases of schizophrenia and 22 cases of psychopathy. The psychopaths fared better than the schizophrenics, the former including 19 patients with some improvement and only 3 who were not improved. The schizophrenics included 18 patients who were not improved. Although the prognosis became worse with the length of hospital treatment in the schizophrenic group, this time factor was of no great importance in the psychopathic group. The length of the interval between the first appearance of symptoms and the lobotomy averaged 13 years (range 1½ to 32 years). The interval between admission to hospital and the lobotomy averaged 7½ years. The patient's age was not found to influence the prognosis.

With an observation period of 2 to 7 years after the lobotomy Foltmann admits worse results than those of his preliminary report. Eleven patients who had been discharged from the hospital had to be readmitted because of relapse. The six psychopaths readmitted could be discharged again after 2 to 13 weeks with almost as much improvement as on their first postoperative discharge, but the five schizophrenics who were readmitted to the hospital because of relapse fared much worse, since they were no better than they had been before the operation and had to be retained in hospital in spite of shock treatment. Foltmann also concludes that a study of the premorbid personality of candidates for lobotomy may prove helpful in forming a prognosis. He also describes an amnesic-anosognosic syndrome that may be the outcome of lobotomy.

Plastic Dressings for Burns and Operative Wounds.—Since the autumn of 1952, Dr. Bertil Olow and Dr. Karl-Erik Hogeman have been testing plastic dressings for burns at the University Hospital in Malmö. By painting or spraying a plastic solution they have succeeded in covering burns with a thin transparent film that adheres to the surrounding intact skin but not to the burn itself. This film has remained adherent to the intact skin for up to 15 days, and meanwhile the healing processes of the sterile burn can be watched daily through the film. These tests are still in a preliminary stage, and hitherto the ability of a film to keep its place over a joint about which there is some movement has not been satisfactory. Experiments are, therefore, being continued in this connection and also in view of any possible toxicity that the constituent elements of the film may present. Dr. Elis Lewin of Gothenburg has experimented since 1947 with plastic dressings for operative wounds. After the usual preoperative treatment of the patient's skin, he paints it with a plastic solution that is also applied to a plastic film of suitable size. After about 30 seconds, when the plastic solution has dried, the transparent film is applied to the skin and becomes firmly adherent. At the completion of a laparotomy, sutures of the skin can be carried through this film if necessary, but it also can be easily removed. A new application of the plastic solution can also be made after the abdominal wall has been sutured, but as yet this easy method of applying a dressing has not been widely adopted.

CORRESPONDENCE

SURGICAL SURVIVAL

To the Editor:—The editorial in the Oct. 24, 1953, issue of THE JOURNAL, "Surgical Survival of the Young and of the Aged," contains a passage that states that elderly patients are more susceptible to anoxia than young patients. This statement is open to debate.

Experiments of German investigators (Ruff, S.: Grundriss der Luftfahrtmedizin, Leipzig, 1944, J. A. Barth, p. 94) in the medium of low pressure chambers, in combination with graduated exercise tests within them, showed that tolerance to oxygen want uniformly increases, that is, susceptibility to anoxia decreases with advancing age. As previously stated (May, S. H.: Air Travel and the Cardiac Patient, *Am. Heart J.* **40**:363, 1950), this should not be too surprising. Variations in oxygen tension and acid-base equilibrium of the blood are chiefly controlled by the chemoreceptor fibers in the aortic and carotid bodies. It must be thought that the challenge to these nerve structures, which is ever-increasing with age, leads to a higher degree of conditioning and/or effectiveness. These reflexes become even more active when pathological conditions such as circulatory or respiratory distress demand constant vigilance. The increased tolerance to oxygen want in older persons is also confirmed by the reduced electrocardiographic changes to gradually increased oxygen want in the higher age groups of healthy persons (May, S. H.: Electrocardiographic Response to Gradually Induced Oxygen Deficiency: I. Response of Normal Hearts in Various Age Groups, *Am. Heart J.* **17**:667, 1939). Probably it may be precisely the decreased susceptibility to anoxia that largely contributes to the amazingly high survival rate of the aged in surgery.

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PATIENTS WITH CANCER

To the Editor:—The article "What Philadelphia Physicians Tell Patients with Cancer," THE JOURNAL, Nov. 7, page 901, is very timely and well prepared. The last paragraph stating that studies are needed to determine which patients with cancer might benefit by being told that they have cancer leads me to believe that the authors are not totally in agreement with the view given by the majority of their medical associates in Philadelphia. I would like to refer to an article published in *The Journal of the Indiana State Medical Association,* April, 1953, entitled "Should Patients Be Told When the Diagnosis Is Cancer?"

I conducted a survey of patients (477) between the ages of 18 and 90 of this area to determine if patients desired to know whether or not they had cancer, whether they desired that their close relatives be told if they were afflicted with cancer, whether they actually thought persons with cancer could be fooled into thinking they did not have it, and who they thought should tell the patient about the diagnosis of cancer. I prepared a questionnaire with room on it for answers and reasons. In general, the greatest number of persons not only desired the truth but also desired that their close relatives be informed. A large majority did not feel that patients could be fooled. An overwhelming number thought the physician should be the one to tell the patient the facts about his illness. There were many extremely thought provoking comments by the patients; a few are included in the article. Many persons expressed the desire for cooperation between the physician, minister, and close relatives in handling the situation. There was no great difference of opinion among age groups and sex, but there was definite evidence that the age group 18 to 35 and that women more than men seemed to express greater trust and confidence in their physician. The age group 36 to 50 seemed more cancer conscious than other age groups. Answers did not seem to vary with occupations or religions; however, persons of the business and professional groups gave more extensive reasons for their answer. Patients repeatedly expressed the desire for truth, conscientiousness, morality, trustworthiness, and a Christian attitude on the part of the physician when handling cancer problems and all patient-doctor relationships.

It is my firm opinion that the patient's desires should be followed in this matter rather than the physician's. There are very few exceptions. Reasons for the patient's knowledge of his condition are given in the article mentioned, as well as the exceptions. I found that patients have reasons for wanting to know the truth about whether or not they have cancer far more numerous and important than physicians ever dreamed of. Patients have shown that they can take it better than the dreadful fear and indecision of whether their physician is trying to shield them from the fact that they actually have cancer. Beside that, the type of treatment employed usually is indicative to an intelligent patient that he probably has cancer.

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EXCHANGE TRANSFUSION IN HEMOLYTIC DISEASE OF THE NEWBORN

To the Editor:—Any case of erythroblastosis fetalis should be taken under care prenatally. Every pregnant woman should have her Rh blood type ascertained. If she is Rh negative and her husband is Rh positive, blood should be drawn in the third month of pregnancy to test for the presence or absence of antibodies to the Rh factor and to be used as a basis for comparison with subsequent samples. This should be done even in primiparas, because of the possibility of previous transfusion with Rh-positive blood, of its intramuscular injection, or of a previous undiagnosed incomplete pregnancy. Other titers may be obtained according to individual discretion, but at least one titer should be obtained in the seventh month of pregnancy for comparison. If there is a rise in titer, hemolytic disease should be anticipated. Generally speaking, those women with the highest rise in titer will deliver the most severely affected infants, but there are rare exceptions to this rule.

If the rise in titer is late (32 weeks or later), the question of induction of labor at 38 weeks arises; this is a controversial point, but should be considered especially if the rise is high and precipitous, always remembering that prematurity carries with it a higher incidence of kernicterus. A titer drawn four to six weeks post partum may show a rise, even if no antibodies were noted during pregnancy. This should be noted for future use. If there is a titer carryover from a previous pregnancy, with no rise in titer during the present pregnancy, hemolytic disease should still be anticipated, although, if the husband is heterozygous for the Rh factor, the child may be Rh negative. Rh-negative blood that is compatible with the mother's serum should be available for transfusion, since it is her antibodies that are responsible for the red blood cell destruction in the child.

When a child of an Rh-negative mother is born, a hemoglobin specimen should be taken from the cord rather than from a capillary (this varies greatly with the time of tying of the cord). A Coombs' test should be done on heel or venous blood from the infant, as well as a complete blood cell count, reticulocyte count, and serum bilirubin determination. (Cord serum bilirubin levels are unreliable, since the bilirubin may escape into the maternal circulation.) In the presence of a positive reaction to a Coombs' test, which indicates that the maternal antibodies are attached to the infant's red blood cells,

the indications for exchange transfusion are one or more of the following factors: (1) a cord hemoglobin of less than 14.5 gm. or a capillary hemoglobin of less than 15.5 gm. at birth; (2) previous history of erythroblastosis in a sibling; (3) prematurity; (4) reticulocytosis over 10%; (5) bilirubinemia over 20 mg. per 100 cc. in first 24 hours or an increase of serum bilirubin at a rate of 1 mg. per 100 cc. per hour; and (6) clinical picture of hepatomegaly, splenomegaly, jaundice, edema, petechiae, and pallor.

The most recent writings on this subject do not discuss the relative merits of multiple small transfusions and exchange transfusion. It has already been established to the satisfaction of Diamond, Levine, Mollison, Cutbush, and others that the clinical course of hemolytic disease of the newborn cannot be forecast and that the results are much better if exchange transfusion is done on all infants that require therapy. In experienced hands, this procedure is not unduly traumatic or of excessively long duration. Aftercare in these patients must be very close. Hemoglobin and serum bilirubin determinations must be repeated frequently (as indicated by results of previous determinations). If anemia recurs, a small transfusion is indicated. If the serum bilirubin level rises beyond 20 mg. per 100 cc., another exchange transfusion is indicated. This happens rarely, but the possibility must be considered.

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CHLOROPHYLL AND DEODORIZATION

To the Editor:—An editorial entitled "Chlorophyll and Deodorization" in the Oct. 24 issue of THE JOURNAL quoted incorrectly from my paper presented before the American Dental Association annual meeting on Sept. 29, 1953. The correct quotation, with the word "protective" reinserted, was "Claims that toothpastes containing chlorophyll can give a protective deodorizing effect for several hours should be viewed with suspicion." The point I was trying to make, and which is missed in the misquotation, is that, since most of the toothpaste placed in the mouth on a toothbrush is quickly diluted by water and saliva, it is expecting a little too much that the amount remaining in the mouth after several hours will offer important protection against new odor agents placed in the mouth. While the deodorizing properties of chlorophyll derivatives have not been a major concern of my research with these materials since 1948, it has been my experience that the majority of samples of chlorophyll derivatives I have worked with will deodorize many substances, if brought in contact with them in sufficient concentration, either in vitro or in the oral cavity.

It is probably a form of justice that the overextravagant promotion of these materials has resulted in an almost fanatic skepticism toward any positive research findings concerning chlorophyll derivatives. Since two wrongs do not make a right, however, I felt it pertinent to point out the correction in respect to the quotation from my paper and my position in respect to deodorization as expressed in the paper.

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To the Editor:—I was interested in the editorial "Chlorophyll and Deodorization" in THE JOURNAL, Oct. 24, 1953, and the correspondence in the same issue. It is understandable that the wide claims for the deodorizing properties of the agent are being questioned. I think it would be a good idea to question some of the other claims that have been made for chlorophyll preparations, especially those relating to an alleged effect on wound healing. I am not familiar with a single clinical or experimental study that has proved conclusively that chlorophyll is beneficial. It is true that many wounds have healed under a chlorophyll ointment, but no untreated control wounds were provided. During World War II, a burn study unit at the Henry Ford Hospital undertook to evaluate chlorophyll, with wound healing experiments on guinea pigs and in clinical wounds of many types (Lam, C. R., and Brush, B. E.: Chlorophyll and Wound Healing: Experimental and Clinical Study, *Am. J. Surg.* **80:**204, 1950). It was our conclusion that it could not be demonstrated that chlorophyll has a therapeutic effect.

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PLASTIC REAGENT BOTTLES FOR ALKALIS

To the Editor:—Anyone who uses strong alkalis, such as sodium hydroxide solution—and this includes most practitioners and medical technicians—wishes at times to avoid somehow the etching properties of these reagents. Because of the etching properties, the inner surface of a glass bottle is dissolved and smudged. The reagent itself becomes a complex suspending a brackish waste that interferes with proper usage. I found it necessary to renew the sodium hydroxide solution in my laboratory every two weeks, and that became a nuisance. These strong alkali reagents are by far the most useful in the everyday hunt for fungi when examining and diagnosing cutaneous lesions and eruptions and excretions from the bronchial tree, lungs, and gastrointestinal tract. Numerous other tests and procedures in the medical and chemical laboratory depend on the availability of a supply of strong alkali solution.

Plastics today are commonplace and are fashioned into a thousand and one objects. They can substitute for practically any structural material. Plastic containers for cosmetics and commercial products fill the shelves of shops and possess very obvious advantages, such as light weight, lack of fragility and brittleness, and the capacity to change shape slightly and therefore to fit in spaces better than rigid glass. Beside, plastics are relatively inert and, unlike glass, do not react with strong alkali. Bottles made of these newer materials should be ideal for storing these reagents. In our laboratory, this was tested, and it was found that strong alkali, such as sodium or potassium hydroxide, solutions keep almost indefinitely without spoiling. Bottles for the purpose come in various styles, shapes, and sizes with short or drawn out necks that open into wide mouths or small tips to deposit even a drop or two. Strong alkali solutions slowly take up carbonic acid from the air and after a time lose part of their clarity; however, if the reagent bottle is kept well stoppered between use, the content remains clear and fresh for years.

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RUPTURE OF AORTIC ANEURYSM INTO ESOPHAGUS

To the Editor:—I have read with interest the article by Drs. Calenda and Uricchio on "Gastrointestinal Hemorrhage Due to Rupture of Aortic Aneurysm into the Esophagus" (*J. A. M. A.* **153:**548-549 [Oct. 10] 1953). These authors correctly emphasize the advisability of considering rupture of an aortic aneurysm in the differential diagnosis of hematemesis and melena. I doubt, however, that rupture of an aortic aneurysm into the esophagus is as rare as they have stated. Certainly more than five cases have been described in the world literature in the past 27 years. Baer and Loewenberg have reported cases of aortic aneurysm rupturing into the esophagus or duodenum (Loewenberg, S. A., and Baer, S.: *Am. Heart J.* **32:**653 [Nov.] 1946; Baer, S., and Loewenberg, S. A.: *Gastroenterology* **10:**617 [April] 1948). In addition, Dr. Harold L. Goldburgh and I discussed the gastrointestinal complications of dissecting aneurysm at some length (Baer, S., and Goldburgh, H. L.: *Am. Heart J.* **35:**198 [Feb.] 1948). Included in this report of 44 cases of dissecting aneurysm are at least 2 cases in which there was rupture of the aneurysm into the esophagus. I believe that a more detailed search of the literature will reveal several other cases in which an aortic aneurysm perforated into the gastrointestinal tract.

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COUNCIL ON MEDICAL EDUCATION AND HOSPITALS

ADDITIONAL HOSPITALS REGISTERED

The following hospitals were registered by the Council on Medical Education and Hospitals of the American Medical Association at its meeting in St. Louis, Nov. 30, 1953:

Ellis-Meyer Hospital Clinic, Decatur, Ala.
El Reposo Sanitarium, Florence, Ala.
Fitts Hill Hospital, Montgomery, Ala.
Randolph County Hospital, Roanoke, Ala.
Mesa Sanitarium, Mesa, Ariz.
Crippled Children's Hospital, Phoenix, Ariz.
Mercy Hospital-Gozzoli Memorial, Brinkley, Ark.
Des Arc General Hospital, Des Arc, Ark.
Baxter County Community Hospital, Gassville, Ark.
Izard County Memorial Hospital, Melbourne, Ark.
Saltzman Hospital, Mountain Home, Ark.
Crawford County Memorial Hospital, Van Buren, Ark.
Cross County Hospital, Wynne, Ark.
Healdsburg General Hospital, Healdsburg, Calif.
Shriners Hospital for Crippled Children, Los Angeles
Westmoreland Sanitarium, Los Angeles
North Hollywood Maternity Hospital, North Hollywood, Calif.
Salinas Valley Memorial Hospital, Salinas, Calif.
California State Polytechnic College Hospital, San Luis Obispo, Calif.
Kit Carson County Memorial Hospital, Burlington, Colo.
Montrose Memorial Hospital, Montrose, Colo.
Simla Community Hospital, Simla, Colo.
Cove Hill Manor, Uncasville, Conn.
Hadley Memorial Hospital, Washington, D. C.
Arcadia General Hospital, Arcadia, Fla.
Manatee Veterans Memorial Hospital, Bradenton, Fla.
Memorial Hospital, Hollywood, Fla.
Grant Haven Convalescent Home, Jacksonville, Fla.
Galey Memorial Hospital, Key West, Fla.
North Shore Hospital, Miami, Fla.
Arlington City Hospital, Arlington, Ga.
Emanuel County Hospital, Swainsboro, Ga.
Carmi Township Hospital, Carmi, Ill.
Memorial Hospital, Carthage, Ill.
Belmont Rest Home, Chicago
Louis A. Weiss Memorial Hospital, Chicago
Mark Howard Home, Chicago
Ogden Park Convalescent Home, Chicago
Veterans Admin. Hospital, Chicago
Wrightwood Home, Chicago
Student Health Service, Northwestern University, Evanston, Ill.
New Glenview Convalescent Home, Glenview, Ill.
Condell Memorial Hospital, Libertyville, Ill.
Marion Memorial Hospital, Marion, Ill.
Whitley County Memorial Hospital, Columbia City, Ind.
Veterans Admin. Hospital, Indianapolis
Clarke County Hospital, Osceola, Iowa
Sioux Center Community Hosp. and Health Center, Sioux Center, Iowa
Lutheran Hospital, Sioux City, Iowa
Community Memorial Hospital, Sumner, Iowa
Hanover Hospital, Hanover, Kan.
Stevens County Hospital, Hugoton, Kan.
Wichita County Hospital, Leoti, Kan.
Cheyenne County Hospital, St. Francis, Kan.
Washington County Hospital, Washington, Kan.
Knox Hospital, Barbourville, Ky.
Clinton and Hickman County Hospital, Clinton, Ky.
New Castle Sanitarium, New Castle, Ky.
Methodist Hospital, Pikeville, Ky.
Henry Cook Pope Hospital, Richmond, Ky.
Clark County Hospital, Winchester, Ky.
Franklin Foundation Hospital, Franklin, La.
Jennings American Legion Hospital, Jennings, La.
Otis General Hospital, Cambridge, Mass.
Springfield Hospital, Springfield, Mass.
Memorial Hospital, Onekama, Mich.
Trenton Medical Hospital, Trenton, Mich.
Sandstone State Hospital, Sandstone, Minn.
Zumbrota Community Hospital, Zumbrota, Minn.
Cosby Hospital-Clinic, Iuka, Miss.
Watkins Memorial Hospital, Quitman, Miss.
Stone County Hospital, Wiggins, Miss.
Sheridan Memorial Hospital, Plentywood, Mont.
Cottage Hospital, Woodsville, N. H.
Hunterdon Medical Center, Flemington, N. J.
Franklin Hospital, Franklin, N. J.
Passaic County Welfare Home, Paterson, N. J.
New Jersey Neuro-Psychiatric Institute, Skillman, N. J.
Meadows Home for the Aged and Chronically Ill, Las Vegas, N. Mex.
Swedish Hospital, Brooklyn
Chronic Diseases Research Institute, Buffalo
Veterans Admin. Hospital, Syracuse, N. Y.
Angel Hospital, Franklin, N. C.
Shaw Memorial Hospital, Oxford, N. C.
Towner County Memorial Hospital, Cando, N. Dak.
Wood County Hospital, Bowling Green, Ohio
Fostoria City Hospital, Fostoria, Ohio
Edmond Hospital, Edmond, Okla.
Moton Memorial Hospital, Tulsa, Okla.
Pacific Communities Hospital, Newport, Ore.
Kalkhof Hospital and Clinic, Erie, Pa.
Valley Forge Heart Institute and Hospital, Fairview Village, Pa.
Wolffe Clinic and Hospital, Philadelphia
Dell Rapids Hospital, Dell Rapids, S. Dak.
Bristol Memorial Hospital, Bristol, Tenn.
Dan German Hospital, Franklin, Tenn.
Laughlin Clinic-Hospital, Greeneville, Tenn.
Kenneth Brown Hospital, Lewisburg, Tenn.
Henry County General Hospital, Paris, Tenn.
Matagorda General Hospital, Bay City, Texas
Bronte Hospital, Bronte, Texas
Hammond Memorial Hospital, Bryan, Texas
Driscoll Foundation Children's Hospital, Corpus Christi, Texas
Navarro Clinic-Hospital, Corsicana, Texas
Dublin Hospital, Dublin, Texas
Eastland Memorial Hospital, Eastland, Texas
Eldorado Clinic Hospital, Eldorado, Texas
Oak Lawn Hospital, Gilmer, Texas
Hamilton Clinic and Hospital, Hamilton, Texas
U. S. Air Force Hospital, Houston, Texas
Jenkins Clinic-Hospital, Hughes Springs, Texas
Jacksboro Hospital, Jacksboro, Texas
Hardin County Hospital, Kountze, Texas
Buey-Glenn Clinic Hospital, Linden, Texas
Medical-Surgical Hospital, Lockney, Texas
Goodnight Hospital, Lubbock, Texas
Crockett County Hospital, Ozona, Texas
Rankin Hospital, Rankin, Texas
Gaines Clinic-Hospital, Seminole, Texas
Briscoe County Hospital, Silverton, Texas
Sinton Hospital, Sinton, Texas
Tomball Hospital, Tomball, Texas
Willapa Harbor Hospital, South Bend, Wash.
Washington State Penitentiary Hospital, Walla Walla, Wash.
St. Luke's Hospital, Bluefield, W. Va.
Staats Hospital, Charleston, W. Va.
Grant Community Hospital, Lancaster, Wis.
Attic Angel Nursing Home, Madison, Wis.
Wisconsin Neurological Hospital, Madison, Wis.
War Memorial Hospital, Powell, Wyo.
Memorial Hospital of Carbon County, Rawlins, Wyo.

BUREAU OF LEGAL MEDICINE AND LEGISLATION

MEDICOLEGAL ABSTRACTS

Scientific Tests: Conclusiveness of Paternity Test.—This was a bastardy proceeding. From judgments for the defendant, the plaintiff appealed to the Essex county court, law division, New Jersey.

The question to be decided by this appeal, said the court, is: In a bastardy proceeding, where the only issue is the paternity of the illegitimate child, is the result of a blood grouping test disproving paternity to be treated as a form of expert evidence not necessarily barring a finding of paternity contrary to the test result, or is it to be considered conclusive evidence of non-paternity?

In seeking the answer to this question, said the court, it is not necessary to be concerned with how such evidence should be considered in a criminal or quasi-criminal proceeding where the blood is obtained without consent or if, as has been suggested, the results of blood grouping tests should be treated differently in those types of proceedings than in civil proceedings. Although certain formal aspects of a bastardy proceeding resemble a criminal rather than a civil proceeding, and although dictum will be found from time to time to the effect that it is of a quasi-criminal nature, it appears settled in this State, as well as in a majority of our sister states, that a bastardy case is a civil proceeding. Furthermore, the parties here consented to the test. In fact, said the court, the test by Dr. Lester Unger was conducted pursuant to an order obtained by the plaintiff while the appeal was pending. The importance of determining the legal effect of a test result of non-paternity is brought into sharp focus by the record in this case. At the first trial in the court below a jury verdict in favor of the plaintiff was set aside by the trial judge. At the second trial, also before a jury, the magistrate directed a verdict in favor of the defendant on the basis of the result of the test performed by Dr. Philip Levine. In this court, although available, a jury trial was not demanded. While the case was pending on appeal here and before trial, the plaintiff applied for an order to have a blood grouping test conducted by Dr. Lester Unger, an expert of her own choosing. Being satisfied as to Dr. Unger's qualifications, an appropriate order was entered by this court, and his report setting forth his findings that defendant could not be the father of the child was admitted in evidence at the subsequent trial. Dr. Levine, one of the world's outstanding authorities in this field, testified at the trial in

V 1
195

this court that the test conducted by him conclusively showed that defendant could not be the father of the child. Dr. Levine further testified that Dr. Unger is recognized as an outstanding serologist and fully competent to perform blood grouping tests. No suggestion is made that these tests were not properly conducted, and the record conclusively demonstrates that they were performed in accordance with the highest standards of accepted practice. Excluding the results of the blood grouping tests, the other evidence in the case preponderates in favor of the plaintiff, and, without these test results, the judgment of non-paternity entered in the court below would have to be set aside and a judgment entered here that the defendant is the father of the child born to the plaintiff.

It is universally accepted in medical and scientific fields, said the court, that the result of a blood grouping test disproving paternity or, to use the language of the statute, indicating definite exclusion of parentage, is not an expression of opinion upon which experts can differ but, rather, is the statement of a scientifically established fact. It is a scientifically established fact just as it is a scientifically established fact that the world is round. As such it should be accepted by the courts of law. For a court to declare that these tests are not conclusive would be as unrealistic as it would be for a court to declare that the world is flat. This a court of law whose prime function is to ascertain truth and administer justice should not do. Accordingly, it is held that the results of the blood grouping tests conclusively establish that the defendant is not the father of the illegitimate child born to the plaintiff.

The judgment in favor of the defendant was affirmed. *Ross v. Marx, 90 A. (2d) 545 (New Jersey 1952).*

153
53

BUSINESS PRACTICE

The following material is based on a public relations manual issued by the Public Relations Department of the American Medical Association.—ED.

TO HELP THE PATIENT PAY

When a man wants to buy an expensive item such as a television set and he does not have ready cash, he often arranges to pay for the set on a weekly or monthly installment plan. Installment buying has become so much a part of the American economic system that there is no reason why medical care cannot be purchased in the same way. Although it is not being too mercenary to help a patient budget for his medical care if the physician's attitude toward the system is right, the suggestion must be implanted tactfully. Unless patients are undergoing extensive treatment, it is generally wise to encourage them to pay for routine visits before they leave the office. Most people come prepared to pay for the call but leave without paying because they hesitate to bring up the subject themselves. The doctor can smooth the way to payment and relieve patients' uncertainty by saying at the end of the visit: "My usual charge for an office call is ———. If you would like to pay today, please stop at my secretary's desk as you leave." Or, if the patient stops at the secretary's desk to make another appointment, the secretary can say: "Would you like to pay for your visit today?" as she reaches for her receipt book. Encouraging pay-as-you-go plans eases the strain on the patient's pocketbook and cuts billing and collecting procedures in the doctor's office.

Patients who cannot pay for their medical care immediately should be given an opportunity to arrange payment plans to suit their needs. Payment plans that allow the patient to pay a certain amount over a period of time make it easier for him to meet the unexpected cost of illness. It is not necessary to use such commercial terms as "installment buying" or "time-payment plans." When a patient is upset at the prospect of paying your fee, it may be suggested: "Mrs. Smith, if you think you will have difficulty paying for your treatments at one time, we can work out some special arrangements." The patient probably will ask what you have in mind, and the discussion very naturally eases into types of payment plans. Payment plans can be handled in the office by the physician and his secretary. For example, in fixed fee cases such as immunizations and periodic check-ups of infants, it is easy to work out an installment plan by dividing the total sum by the probable number of calls or number of months during which care will be provided and asking the patient to pay a portion of the sum at monthly intervals or at each visit. Suppose a patient comes to the office during the third month of pregnancy. She can work out a seven-month payment plan with the doctor and make her last payment correspond with her last postnatal visit.

When the time element is not definite, a 10 month or 12 month period is usually agreeable to both patient and physician for budgeting medical care. The physician must carefully explain just what medical services are being provided for the monthly sum, however, so that should an emergency arise that requires additional treatment during this period, the patient is not angry when he finds he must pay a larger sum than that agreed on. Sometimes a physician can offer an installment plan to patients who are several months behind in their payments. A doctor might send a little card with a message reading something like this: "Instead of mailing you your statement, I am sending you this card so you can remit small monthly payments to clear up your account. Just return your check or a cash amount with this card, and we will receipt it and return it so you can use it again next month." This informal approach is much less frightening than a formal promissory agreement, and the patient usually is relieved that his medical bills can be settled so easily.

Banks, reputable loan companies, and other organizations sometimes offer plans for financing medical bills. Medical societies, too, in some areas have set up medical credit bureaus to help patients meet their medical obligations. These organizations usually pay the doctor in full for his services and lend the money to patients at a small rate of interest. Physicians often deduct the interest charges from their fees. The doctor may suggest to his patient that such plans are available and perhaps give a card of introduction to the bank or bureau if the patient is interested. There are certain dangers in outside financing of medical bills—unscrupulous organizations could press patients for payments in an unethical way, creating bad feeling. The physician should carefully investigate any such available plans and determine if their use is justified. However, ethical plans can be a real service to patients who honestly want to pay their medical bills.

MEDICAL MOTION PICTURES

The Warning Shadow: 16 mm., color, sound, showing time 16 minutes. Produced in 1953 by Herbert Kerkow for the American Cancer Society and the National Cancer Institute. Procurable on loan from the American Cancer Society, 47 Beaver Street, New York 4.

This is a fine picture of a dramatic subject. The opening portion, dealing with the first successful pneumonectomy on a patient (who happened to be a doctor), has simplicity and a sincerity that carries conviction. The average layman, to whom this picture is directed, will be much impressed by the fact that a physician had the same problem as the layman when considering an operation of such severity. The fact that neither the patient nor the surgeon discussed in the picture are actors adds an authenticity to the story that cannot be secured by statistics or scientific detail. Later on, a group of successfully treated lung cancer patients are shown. These persons, who are now apparently healthy, may be the means of saving the lives of thousands of others. It is not a technical picture and should not be considered as such. The information presented is sufficient to stimulate interest and action on the part of a possible patient and, most important, refer him to his doctor for information and diagnosis. This picture is heartily recommended for lay groups of either men or women. The photography and narration are excellent.

MEDICAL LITERATURE ABSTRACTS

UNITED STATES

A.M.A. Am. J. Diseases Children, Chicago

86:395-552 (Oct.) 1953

*Reactions Following Antirabies Prophylaxis. N. H. Blatt and M. H. Lepper.—p. 395.
*Electrophoretic Analyses of Plasma or Serum Proteins of Rheumatic Fever Patients in Relation to Stages of Disease. R. L. Jackson, H. G. Kelly, E. K. Smith, P. Wang and J. I. Routh.—p. 403.
New Treatment for Atelectasis of Newborn. W. G. Love Jr. and B. Tillery.—p. 423.
Growth and Metabolism in Normal and Thyroid-Ablated Infant Rhesus Monkeys (Macaca Mulatta). L. B. Lusted, D. E. Pickering, D. Fisher and F. S. Smyth.—p. 426.
Completely Automatic Miller Aerosol Device. C. M. Trossman.—p. 436.

Reactions Following Antirabies Prophylaxis.—Reactions to rabies vaccine developed in 16 patients, all but one of whom came from a group of 2,193 persons who received antirabies inoculations from the Chicago Health Department in 1950, 1951, and the first three months of 1952. Eight patients had reactions without evidence of central nervous system involvement, and eight had reactions with such signs. One of this second group died, and three had residual neurological symptoms after treatment. The signs and symptoms of antirabies vaccine reaction indicating that therapy should be discontinued are principally occurrence of an otherwise unexplained fever, paresis, radicular pain, and headache. Any otherwise unexplainable complaint must be regarded as suspicious. An intradermal skin test using antirabies vaccine diluted to 1:10 was found to be positive in all patients in whom a clinical reaction to rabies vaccine developed; but it was positive in 60% of all patients being vaccinated. Persons who have not been inoculated with rabies vaccine have negative skin tests. Corticotropin was given to three of the patients with the most serious involvements. Two responded well, and the third, who received the drug late in the course of the disease, had only questionable benefit. It was suggested but not proved that corticotropin may have been effective in treating these patients.

Plasma or Serum Proteins in Patients with Rheumatic Fever.—A detailed study of the plasma or serum proteins of 77 children with definite rheumatic fever and five patients with chorea without other manifestations of rheumatic fever is reported. The total proteins and percentage composition of albumin, alpha$_1$ globulin, alpha$_2$ globulin, beta globulin, fibrinogen, gamma' globulin, and gamma globulin of the blood are given for patients in the following stages of the disease: (1) early acute without decompensation, (2) late acute without decompensation, (3) early, middle, and late subacute without decompensation or recent infection or exacerbation, (4) inactive without recent infection or exacerbation, (5) acute with decompensation, (6) early, middle, and late subacute without decompensation but with recent mild intercurrent infection or exacerbation, (7) active chorea only, and (8) remittent type in various stages. The changes in the serum protein components of the blood that take place along with the antibody response when a child's system adjusts to acute disease were found to have a definite pattern, as evidenced by the 205 plasma or serum specimens analyzed in the course of this study. The percentage composition of albumin, fibrinogen, and the globulins alpha$_1$, alpha$_2$, gamma', and gamma is markedly altered in the acute stage of the disease. The return to normal mean values as the disease regresses is gradual for albumin, fibrinogen, and alpha$_2$ and gamma globulins; alpha$_1$ and gamma' globulins are elevated generally only in the acute stage. Changes in the percentage composition of beta globulin are not correlated with the stages of the disease; the mean values for total proteins are slightly elevated for all subgroups of uncomplicated rheumatic fever and significantly elevated in the late subacute stage. The mean values of serum protein fractions for the group of patients with inactive rheumatic fever indicate that the patients as a group are capable of normal protein metabolism.

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Titles marked with an asterisk (*) are abstracted.

A.M.A. Arch. Ophthalmology, Chicago

50:401-544 (Oct.) 1953

Comparative Chemistry of Aqueous Humor in Posterior and Anterior Chambers of Rabbit Eye: Its Physiologic Significance. V. E. Kinsey.—p. 401.
Simulated Progression of Visual Field Defects of Glaucoma. R. McC. Day and H. G. Scheie.—p. 418.
Type of Paralysis of Conjugate Gaze (Ocular Motor Apraxia). D. G. Cogan and R. D. Adams.—p. 434.
*Endogenous Uveitis in Children: Associated Band-Shaped Keratopathy and Rheumatoid Arthritis. M. D. Davis.—p. 443.
Idiopathic Hypoparathyroidism and Cataract: Report of Four Cases. A. S. Haft.—p. 455.
Hereditary Polymorphous Deep Degeneration of Cornea. H. B. McGee and H. F. Falls.—p. 462.
Tumor of Optic Disk Associated with Neurofibromatosis: Presentation of Case. R. H. Trueman and I. E. Rubin.—p. 468.
Anomalous Binocular Depth Perception Due to Unequal Image Brightness. P. W. Miles.—p. 475.
*Hyperophthalmopathic Graves's Disease: Clinical Observations in 19 Cases. T. R. Hedges Jr. and E. Rose.—p. 479.
Respiration of Ciliary Processes. A. deRoetth Jr.—p. 491.
Glucose Utilization of Retina. II. Influence of Various Hormones on Glucose Utilization of Retina. W. Kornblueth, E. Yardeni-Yaron and E. Wertheimer.—p. 500.
Echinococcus Cyst of Eyeball. O. Litricin.—p. 506.

Endogenous Uveitis in Children.—The occurrence of active endogenous uveitis was observed in five girls and seven boys between the ages of 5 and 15 years. The disease was diagnosed as chorioretinitis without anterior segment involvement in 2 of the 12 patients, while it was described as iritis or iridocyclitis, with or without posterior involvement, in the remaining 10. Of the 10 patients, 4 had definite concurrent rheumatoid arthritis and 2 had a history of "arthritis" without any residual joint deformity. No other causative factor was noted in any of these patients, except for sarcoidosis in one. The cause was undetermined in the remaining four patients. The anterior uveitis was of granulomatous type in two patients, nongranulomatous in three, and of quiet serous type in five. This last type was noted in most of the cases of iritis associated with juvenile rheumatoid arthritis collected from the literature. Of the author's five patients with this last type of anterior uveitis, three had definite rheumatoid arthritis, one had a history of arthritis, and in one the cause was undetermined. Two of the 10 patients with anterior uveitis, associated with typical rheumatoid arthritic deformities of the proximal interphalangeal joints bilaterally and sarcoid lesions on the extensor surfaces of both arms in one, and with synovial thickening of the enlarged right knee joint in the other, are described in detail. A brief review of the literature on the triad of band-shaped keratopathy, iritis, and juvenile rheumatoid arthritis is presented, and the association of rheumatoid arthritis with juvenile uveitis is stressed.

Hyperophthalmopathic Graves' Disease.—The clinical picture of 19 patients with hyperophthalmopathic Graves' disease reported on by Hedges and Rose was dominated by severe or progressive ocular signs. Proptosis was symmetrical in 10 patients and asymmetrical in 9 at the onset of exophthalmos. Congestive signs were present without corneal damage in

seven patients and with corneal damage in four. Eight patients showed no congestive signs at any time. Limitation of ocular movement was noted at the time of first examination in 11 patients. Seven patients suffered some loss of visual acuity, but eventual recovery of vision was notable in all. Two of these patients showed central visual field defects indicative of optic nerve fiber bundle damage. Exophthalmos attained its maximum in from 4 to 12 months in 16 of the 19 patients. Recession, varying from 3 to 7 mm., occurred in from 1 to 6 years in 8 patients, while no significant recession from maximum levels occurred during 2 to 12 years in 11 patients. When progressive, hyperophthalmopathic syndrome generally tended to become stabilized in from 4 to 12 months after which the inflammatory, congestive, and sympathicotonic manifestations tended to regress and the proptosis either remained stationary or gradually receded. Of the 19 patients, 14 manifested initially some degree of thyrotoxicosis; of 4 euthyroid patients, 2 may have been previously thyrotoxic; and 1 patient remained hypothyroid throughout. Seven of the 19 patients received thiouracil compounds and stable iodine over long periods. When the metabolic rate returned to normal, there was no increase in ophthalmopathy. Partial thyroidectomy was done in the presence of exophthalmos in four patients with no subsequent exacerbation of the ophthalmopathy. Treatment of thyrotoxicosis in 11 patients caused no significant exacerbation of the ocular syndrome. Nine of the 19 patients received desiccated thyroid and diethylstilbestrol over long periods. No correlation between this treatment and the course of the ophthalmopathy was observed. Eighteen patients received irradiation treatment to the pituitary; a significant recession in exophthalmos occurred in only two patients. Seven patients showed gradual decrease in congestive ocular signs within four to six months. In five of these patients treatment was given after the ophthalmopathy had been present for six to eight months. It is possible that a spontaneous regression in congestive signs could explain this apparent improvement. The authors' observations failed to indicate a relationship between the onset and course of the ophthalmopathic phenomena and those of associated thyroid dysfunction. The concept that exophthalmos is divided into the thyrotropic and the thyrotoxic form is not tenable. The possible role of orbital tissue hypersensitivity in the pathogenesis of hyperophthalmopathic phenomena of Graves' disease is suggested. Evaluation of therapy in patients with hyperophthalmopathic Graves' disease is hampered by the tendency toward spontaneous remissions and exacerbations and by the lack of control studies. The use of stable iodine and desiccated thyroid and, in selected progressive cases, pituitary irradiation seems to be safe therapeutic policy. Local measures may be employed when indicated. Surgical decompression of the orbit is a measure of last resort.

American Journal of Surgery, New York

86:361-488 (Oct.) 1953

Treatment of Wound Infections with Furacin Soluble Powder. C. E. Friedgood and C. B. Rpstein.—p. 363.
Anesthesia for Surgery of Thyroid Gland. F. P. Ansbro, A. Blundell, B. Bodell and others.—p. 368.
*Spontaneous Involution of Cutaneous Vascular Tumors. F. Ronchese. —p. 376.
Treatment of Cancer of Floor of Mouth and Tongue. S. Krantz, E. D. Grady and J. B. Holloway.—p. 387.
Control of Pain from Rectal Carcinoma Without Sedation. L. G. Bodkin. —p. 395.
Control of Deltoid Bursitis with Knott Technic of Blood Irradiation Therapy. G. P. Miley and A. A. Laplume.—p. 401.
Arteriography of Hip Joint for Predicting End Results in Intracapsular and Intertrochanteric Fractures of Femur. F. W. Rook.—p. 404.
Review of Spina Bifida and Cranium Bifidum, with Follow-Up Studies of 81 Cases. G. Owens.—p. 410.
Fibrositis and Disc Syndrome. N. G. Long and T. A. Lamphier.—p. 414.
Adenocarcinoma in Horseshoe Kidney. R. Schoonover.—p. 417.
Sarcoma Involving Spleen. C. B. Ripstein and M. Virshup.—p. 422.
Cholecystectomy and Sphincterotomy for Biliary Dyskinesia: Clinical Attempt to Define Indications. H. Sneierson.—p. 429.

Spontaneous Involution of Cutaneous Vascular Tumors.—For the last five years 59 private patients with vascular tumors (almost all having strawberry and cavernous hemangiomas) have been left untreated by Ronchese. Letters sent to the patients to learn about the results were answered by 33; 24 of these stated that the birthmark had disappeared completely or that the remnants were cosmetically satisfactory; 4 said that the birthmark did not change, and 5 were treated by surgery or irradiation. The occurrence of spontaneous involution of a cutaneous vascular tumor is described in three patients. A doughy, doughnut-shaped, flesh-colored tumor below the knee of the first patient, a baby boy two weeks old, vanished in six months leaving only a slightly wrinkled surface. "Spontaneously developing and spontaneously involuting telangiectasis" appeared several times in the same area of the left cheek of the second patient, a man aged 75, and lasted only a few days. This occurred several times over a period of months and was symptomless. There was no clue as to the cause. The third patient was a baby girl 16 days old with a rubbery, blue-green patch on her right lower abdominal quadrant. Because of its consistency, it suggested fat necrosis of the newborn and hemangioma. It involuted after six months. It is difficult to determine the exact percentage of spontaneous involution of cutaneous vascular tumors because of the prevailing opinion, especially among radiologists and surgeons, that it is unwise or dangerous to leave hemangiomas untreated. There is also parental unwillingness to wait for three or four years for spontaneous involution. Consequently the great majority of such patients receive treatment in one form or another. The author does not advocate expectant therapy for all cases; however, being convinced that a large majority do involute spontaneously, he is in favor of no therapy in selected cases in which the lesions are located in covered body areas or may be easily removed surgically at a later date in the event spontaneous involution does not occur. Treatment usually is indicated in exposed parts if the hemangioma is small because there are easy, quick, and safe methods, or if it is large because it may be "the exceptional one" that will not vanish and later therapy will be more difficult. Expectant therapy has its place with the use of radium and should be given due consideration.

Annals of Internal Medicine, Lancaster, Pa.

39:433-674 (Sept.) 1953

Aspects of Action of Insulin. C. H. Best.—p. 433.
*Clinical Evaluation of Isoniazid. S. S. Cutler, B. Burbank and B. Battaglia.—p. 444.
*Results Following Pulmonary Resection of Tuberculous Disease with Special Reference to Localized Necrotic Lesions. J. H. Forsee, C. W. Tempel and E. L. Scott.—p. 463.
Late Results of Treatment of Solitary Dense Tuberculous Pulmonary Focus (Tuberculoma) Without Resection or Chemotherapy. R. S. Mitchell.—p. 471.
Cholangiography. P. G. Keil, G. J. Hegstrom and S. J. Zoeckler.—p. 479.
Management of Biliary Tract Disorders in Patients with Heart Disease. J. R. Twiss, R. F. Carter and S. Goldenberg.—p. 484.
Rheumatism and Arthritis: Review of American and English Literature of Recent Years; (Tenth Rheumatism Review): Part I. W. D. Robinson, E. W. Boland, J. J. Bunim and others.—p. 498.

Clinical Evaluation of Isoniazid.—Isoniazid alone was given a therapeutic trial in 61 tuberculous patients with active and potentially reversible exudative, caseating, or cavernous lesions. After a preliminary control period of three weeks of bed rest without drug therapy, isoniazid was given to each patient in daily doses of 3 to 4 mg. per kilogram of body weight, divided into three doses. If there was a substantial gain in weight, the dose of isoniazid was usually increased. It was planned to treat each patient with isoniazid alone for a minimum of three months after the control period of bed rest. In some patients, the lack of improvement or even the progression of the disease made it unwise to follow this plan rigidly. Isoniazid was discontinued, and streptomycin and *p*-aminosalicylic acid were substituted. Direct comparison of these drugs was thus afforded in these patients. Results showed that isoniazid is probably less effective than streptomycin in patients with caseocavernous pulmonary or extrapulmonary tuberculosis, while isoniazid is probably superior to streptomycin in those with tuberculous meningitis. This superiority in meningitis may be due to the potent intracellular activity of isoniazid, as well as to its superior diffusibility into the meninges. The therapeutic response of basal pulmonary tuberculosis to isoniazid is less dependable and more variable than to streptomycin and *p*-aminosalicylic acid. Favorable changes

in the chest roentgenogram were obtained in 43 (70%) of the 61 patients, while unfavorable radiographic changes were observed in the remaining 18 patients (30%). In 30 patients who were febrile during the preliminary control period, 14 remained febrile under isoniazid therapy, 7 became afebrile within one month of treatment, 6 within two months, and 3 within three months. Fifty patients gained a total of 577 lb. (261.7 kg.) during three months, for an average gain of 11.54 lb. (5.23 kg.). The extremes were a gain of 37 lb. (16.8 kg.) and a loss of 16 lb. (7.3 kg.). Many patients gained weight during the preliminary control period at a rate equal to or greater than the gain while under treatment with isoniazid. Clinical evidence was obtained of a "dissociation" of the therapeutic effect of isoniazid that consisted of simultaneous resolution of one lesion with progression of another in the same patient. It is suggested that many patients are infected with multiple strains of Mycobacterium tuberculosis some of which are resistant to isoniazid and others sensitive. The interaction of anatomic factors, such as the opening or closing of a bronchiole or the alteration of lymph flow by inflammation or fibrosis of a draining lymph node, and immunologic factors in different organs, with the seeding by chance of these organs with different ratios of resistant to sensitive strains of bacteria, is sufficient to explain the variations of response to isoniazid observed in the authors' patients. Visualization of the tuberculous infection as consisting of the action of antibiotics upon a heterogeneous population of numerous organisms with all degrees of sensitivity to streptomycin, isoniazid and *p*-aminosalicylic acid, strongly support the simultaneous use of these three drugs.

Pulmonary Resection for Tuberculous Disease.—Pulmonary resection for localized necrotic tuberculous lesions of the lung were performed on 221 patients who were followed one to five years postoperatively. The lesions involved only one lobe and were limited to an area not exceeding the extent of a minimal lesion as defined by National Tuberculosis Association standards. Of the 221 patients, 69 had cavitary lesions, 2 diffuse caseopneumonic, 96 caseonodose, and 54 tuberculoma. Excision was accomplished by wedge resection in 68 patients, segmental resection in 38, and lobectomy in 115. The postoperative management included bed rest and hospitalization for approximately one year. Results from excision of necrotic tuberculous pulmonary lesions were gratifying. The operative mortality was 0.5%. The incidence of postoperative tuberculous complications was 3.2%, late pulmonary reactivation 2.2%, and late extrapulmonary reactivation (axillary and cervical adenitis) 0.9%. Four patients were lost to observation, and 207 (93%) of the remaining 216 are alive and well; 75% of those operated on prior to 1952 are working. The authors' study is a retrospective one dating back to 1947, and during this period much progress was made in the treatment of pulmonary tuberculosis.

California Medicine, San Francisco

79:207-270 (Sept.) 1953

Obstructive Urinary Tract Lesions in Children. E. Burns.—p. 207.
Phenylbutazone: Evaluation of Its Use. W. G. Snow.—p. 211.
Anoxemia and Brain Disease. C. B. Courville.—p. 214.
Treatment of Intraoral Carcinoma: Combined Resection of Jaw and Radical Dissection of Neck. N. J. Wilde.—p. 218.
Diagnosis and Treatment of Gouty Arthritis. J. H. Talbott.—p. 220.
*Sublingual Administration of Curare. W. B. Neff and H. Mayer.—p. 227.
Stenosis of Urethral Meatus in Boys: Surgical Correction. J. H. Kaplan and W. M. Tasem.—p. 231.
Primary Cutaneous Coccidioidomycosis: Criteria for Diagnosis and Report of Case. J. W. Wilson, C. E. Smith and O. A. Plunkett.—p. 233.
Relationships in Consultation. H. K. Graham.—p. 240.

Sublingual Administration of Curare.—Neff and Mayer point out that the relatively short duration of action produced by the intravenous administration is desirable when curare is used in anesthesia and neuropsychiatry. When curare is used in diseases in which spasm of the voluntary muscles is a feature, however, a long, continued but lower level of curarization is desirable. In order to achieve this, it was decided to resort to sublingual administration, which had been originally suggested by Erdei of Toronto. The first preparation used by Neff and Mayer was in the form of sublingual pellets containing 2 mg. of *d*-tubocurarine per pellet. The pellets now used contain 3 mg. of *d*-tubocurarine and, when administered sublingually, disintegrate in from 20 to 30 minutes. Sublingual administration of curare was used in patients with painful muscle spasm, who were refractory to both narcotics and mephenesin. One patient had episodes of severe back pain and muscle spasm after laminectomy; opiates afforded only partial relief, and mephenesin did nothing. Sublingual administration of curare relieved the muscle spasm and pain. In another patient with fracture dislocation of the neck, who was completely paralyzed below the seventh cervical vertebra, recovery was complicated by paroxysms of muscle spasms in both lower extremities. Narcotics gave only partial relief, and mephenesin gave no relief. Sublingual administration of curare provided sufficient relief to permit the complete withdrawal of narcotics. Contractions still occurred, but they were less severe and no longer associated with severe pain. The dose of curare needed to bring this about was 12 mg. four times daily and sometimes once during the night. The patient placed two 2 mg. pellets under his tongue and repeated this at 20 minute intervals until a total of six pellets (12 mg.) had been taken. Orders were given not to swallow or talk during the administration. When the drug was taken sublingually in therapeutic dosage by the authors (in the absence of any clinical lesion) no subjective effect whatsoever was noted. The method proved valuable also as an adjunct; for instance, it relaxed cervical muscle spasm in torticollis resulting from partial subluxation, prior to neck traction. It alleviated the symptoms of the scalenus anticus syndrome, averting in many cases the need for severing the muscle. The drug is also of value in differential diagnosis; for instance, in determining whether pain in neck or back is due to muscle spasm from nervous tension or to organic changes. Puzzling abdominal pain may be explained since the drug will relieve pain caused by abdominal muscle spasm from a rectus tear or strain, but will not influence the smooth muscle spasm of uterine cramps or a bowel lesion. Although the drug works best on muscles that are palpably in spasm, it also relieved pain caused by intramuscular injection of meralluride (Mercuhydrin). In general, the sublingual administration of curare was more effective than mephenesin.

Circulation, New York

8:481-640 (Oct.) 1953

*Reactivation of Rheumatic Fever Following Mitral Commissurotomy. L. A. Soloff, J. Zatuchni, O. H. Janton and others.—p. 481.
*Antibiotic Therapy of Bacterial Endocarditis: IV. Successful Short-Term (Two Weeks) Combined Penicillin-Dihydrostreptomycin Therapy in Subacute Bacterial Endocarditis Caused by Penicillin-Sensitive Streptococci. J. E. Geraci and W. J. Martin.—p. 494.
Relation of Age to Certain Electrocardiographic Responses of Normal Adults to Standardized Exercise. H. M. Silver and M. Landowne.—p. 510.
Age Changes in Heart Rate and Blood Pressure Responses to Tilting and Standardized Exercise. A. H. Norris, N. W. Shock and M. J. Yiengst.—p. 521.
Lewis A. Connor Memorial Lecture: Physiology of Cardiac Output. W. F. Hamilton.—p. 527.
Failure to Reduce Size of Experimentally Produced Myocardial Infarcts by Cortisone Treatment. D. F. Opdyke, A. Lambert, H. C. Stoerk and others.—p. 544.
Congenital Aneurysm of Right Sinus of Valsalva, Diagnosed by Aortography. W. Falholt and G. Thomsen.—p. 549.
Electrocardiographic Leads: I. Introduction. R. McFee and F. D. Johnston.—p. 554.
Kinetocardiogram: III. Distribution of Forces over Anterior Chest. E. E. Eddleman Jr. and K. Willis.—p. 569.
Method of Securing Direct Body Ballistocardiogram by Means of Microscope, Giving a Record Readily Calibrated. E. W. Bixby and C. B. Henderson.—p. 578.
Torsion Ballistocardiography: With Special Reference to Patterns in Surgically Amenable Cardiovascular Diseases. K. R. Reissmann and E. G. Dimond.—p. 585.
Significance of Intermediate Korotkoff Sounds. S. Rodbard.—p. 600.
Vectorcardiography. G. E. Burch, J. A. Abildskov and J. A. Cronvich.—p. 605.

Reactivation of Rheumatic Fever After Mitral Commissurotomy.—Of 179 consecutive patients who underwent mitral commissurotomy, 67 had recurrent chest pain after discharge from the hospital; 43 (24%) had a febrile syndrome characterized by the appearance of an episodic recurrence of a combination of events first occurring after a variable latent period after the surgical intervention. It was uniformly character-

ized by precordial pain and fever, frequently associated with precipitation or intensification of heart failure and was at times accompanied by migratory joint pains, arrhythmias, hemoptysis, or psychosis. It terminated in death in three patients. The syndrome is regarded as a reactivation of rheumatic fever because of its frequency after mitral commissurotomy and its absence after any other nonrheumatic cardiac or pulmonary surgical intervention and because of the frequent cardiac involvement. The authors believe that the incidence of this syndrome is even greater than that reported in this paper because (1) the incidence in those patients they had the opportunity of following personally is higher, (2) they have seen in consultation several patients in whom fever was not recognized because the temperature was either not taken (the pain was regarded as of incisural origin) or taken incorrectly, and (3) several of the referring physicians were using large amounts of salicylates routinely after hospitalization, a practice that the authors approve.

Antibiotic Therapy of Bacterial Endocarditis.—Short-term combined treatment with penicillin and dihydrostreptomycin for two weeks was given to 16 men and 7 women with subacute bacterial endocarditis caused by penicillin-sensitive streptococci. A low-grade fever, malaise, anorexia, tiredness, and weakness characterized the illness of most. The presence of a heart murmur was the clue to the source of the patient's difficulty. Rheumatic heart disease was present in 18 patients, degenerative or "arteriosclerotic" heart disease in 3, and syphilitic heart disease with syphilitic aortic insufficiency in one. In one patient, it was not possible to state whether any preexisting heart disease was present. Anemia, noted in 15 of the 23 patients, was mild in 12 and moderate in 3. The values for hemoglobin ranged as low as 6.2 gm. per 100 cc. of blood and averaged 10.3 gm. Leukocyte and differential counts were abnormal in only a few patients. Eighteen patients (78%) remained well during follow-up periods of from 3 to 24 months. No therapeutic failures or relapses occurred in the living patients. Five patients (22%) died. Four of the deaths were due to complications of the endocarditis and the underlying heart disease, namely, congestive heart failure and cerebral embolism, while the fifth was due to coronary occlusion with myocardial infarction. One million units of aqueous procaine penicillin G and 1 gm. of dihydrostreptomycin sulfate given intramuscularly every 12 hours for two weeks represent adequate and curative treatment for subacute bacterial endocarditis caused by penicillin-sensitive streptococci.

Fertility and Sterility, Philadelphia

4:345-438 (Sept.-Oct.) 1953. **Partial Index**

*Peritoneal Factor in Female Sterility. E. G. Murray.—p. 371.
Urethrography: Its Value in Study of Male Fertility and Sterility. M. L. Brodny.—p. 386.
Round Multinucleated Spermatogenetic Cells. B. G. Maroulis.—p. 412.
Outcome of Pregnancy in Women Attending a Fertility Clinic. G. I. M. Swyer.—p. 416.
Use of Polyethylene in Tuboplasty. W. J. Mulligan, J. Rock and C. L. Easterday.—p. 428.

Peritoneal Factor in Sterility.—Murray feels that the tubo-ovarian space, which is covered by peritoneal serosa and connects the surface of the ovary with the abdominal end of the tube, is a part of the ovular migration system and must be considered in the study of sterility in women because a lesion in this space may interfere with follicular ripening, ovulation, migration of the ovum to the tube, and the reception of the ovum by the infundibulum of the tube. Such lesions are similar to tubal obstruction in their consequences and are designated as pelvic blockage. The author has been concerned with this aspect of sterility for more than 10 years and has found pelvic blockage in 234 of 2,017 patients (11.6%) examined. Pelvic blockage may be the result of anatomic and functional factors. Anatomic blockage may be of the following types: ovarian, tubal, simple peritoneal, noncommunicating sacciform peritoneal, and communicating sacciform peritoneal. The cause of functional blockage lies in the fixation and retraction of one or other organ or in muscular or nervous lesions that interfere with the approximation movement of the tubal infundibulum to the ovarian surface. These processes are usually due to inflammation of the pelvis from postabortion or puerperal septic infections, gonorrhea, and genital tuberculosis. Other pathogenic factors are surgical trauma and its sequelae, external endometriosis after intrauterine maneuvers, inflammation of the neighboring organs, and peritoneal irritation caused by foreign substances (sulfonamides). In the diagnosis of pelvic blockage, gynecologic examination may have to be supplemented by hysterosalpingography, kymographic persufflation, laparoscopy, and culdoscopy. Medical therapy is similar to that of tubal obstruction, and includes the use of estrogens, diathermy, tubal persufflation, vitamin A, and, finally, cortisone, because of its action on connective tissue. With the aid of such measures, the author obtained some satisfactory results, in that 18 pregnancies resulted among 168 treated patients. When clinical measures have proved useless, surgical treatment may be necessary to remove adhesions, bands, septums, and hypertrophic scars; for peritoneal reconstruction of raw surfaces; and for the approximation of the ovary to the ostium of the tube. The results obtained with surgery were not outstanding because of the irreversible nature of many of the conditions or their tendency to recur. The intrauterine or peritoneal use of penicillin may prove of prophylactic value. In experiments on rats, a reduction of cicatrization was obtained with the use of cortisone and corticotropin, but, in humans, their use is still in the experimental stage.

Illinois Medical Journal, Chicago

104:233-292 (Oct.) 1953

Both Bone Fractures of Leg: Principles of Treatment. C. Scuderi.—p. 233.
Preventive Psychiatry for the Physician. J. M. Caldwell.—p. 236.
Mediastinal Tumors. T. M. Christie and I. Weissman.—p. 242.
Public Relations. J. A. Waggener.—p. 252.
Clinical Evaluation of New Antitussive Agent. S. Hyman and S. H. Rosenblum.—p. 257.
Social and Psychological Factors in Breakdown of Displaced Persons. G. Fenyes.—p. 260.

Journal of Clinical Investigation, New York

32:915-1052 (Oct.) 1953

Partial Purification of Human Prothrombin and Proconvertin: Their Characteristics and Interaction. J. H. Lewis and J. H. Ferguson.—p. 915.
Hemodynamic Effects of 1-Hydrazinophthalazine (Apresoline) in Human Pregnancy: Results of Intravenous Administration. N. S. Assali, S. Kaplan, S. Oighenstein and R. Suyemoto.—p. 922.
Studies in Edema: IV. Water Retention and Antidiuretic Hormone in Hepatic and Cardiac Disease. A. G. White, G. Rubin and L. Leiter.—p. 931.
Studies in Steroid Metabolism: XIX. α-Ketosteroid Excretion Pattern in Normal Males. K. Dobriner.—p. 940.
Id.: XX. Reproducibility of Urinary Steroid Pattern in Humans. K. Dobriner.—p. 950.
Local Blood Flow in Human Bone Marrow in Leukemia and Neoplastic Diseases as Determined by Clearance Rate of Radioiodide (I^{131}). N. L. Petrakis, S. P. Masouredis and P. Miller.—p. 952.
Use of Modified Globin as Protein Supplement in Normal Individuals. C. Waterhouse, E. H. Keutmann and L. D. Fenninger.—p. 964.
Regulation of Renal Bicarbonate Reabsorption by Plasma Carbon Dioxide Tension. A. S. Relman, B. Etsten and W. B. Schwartz.—p. 972.
Clinical and Experimental Study of Erythrocyte Ultrastructure Membrane with Electron Microscope. B. Sundharagiati and C.-S. Wright.—p. 979.
Determination of Plasma Volume in Man with Radioactive Chromic Chloride. H. Frank and S. J. Gray.—p. 991.
Simultaneous Determination of Red Cell Mass and Plasma Volume in Man with Radioactive Sodium Chromate and Chromic Chloride. S. J. Gray and H. Frank.—p. 1000.
*Storage of Blood Below 0 C. in Liquid State. A. Lorant, G. J. Lorant, A. Angrist and R. Korpman.—p. 1005.
Alterations of Fluid and Electrolyte Distribution and Renal Function in Diarrhea of Infancy. A. L. Katcher, M. F. Levitt, A. Y. Sweet and H. L. Hodes.—p. 1013.
Cardiac Output at Rest in Laennec's Cirrhosis. H. J. Kowalski and W. H. Abelmann.—p. 1025.
New Method for Estimating Serum Acid Phosphatase of Prostatic Origin Applied to Clinical Investigation of Cancer of Prostate. W. H. Fishman, R. M. Dart, C. D. Bonner and others.—p. 1034.
Observations on Pain Produced by Injection of Hypertonic Saline into Muscles and Other Supportive Tissues. O. Steinbrocker, S. A. Isenberg, M. Silver and others.—p. 1045.

Storage of Blood Below 0 C (32 F) in Liquid State.—Lorant and associates point out that the importance of refrigeration in the preservation of blood was recognized by Rous and Turner in 1916. The temperatures most suitable for survival of human red blood cells were found to lie between 4 and 9

C (39 to 48 F) with an optimum at about 7 C (44.6 F). Temperatures above 10 C (50 F) favor more rapid deterioration of erythrocytes. Storage temperatures below 0 C could not be evaluated because blood freezes and then hemolyzes completely on melting. At temperatures below freezing, blood can be kept liquid by the use of high pressures and by ethyl alcohol. Investigations on the preservation of blood with these aids revealed that the damage caused by pressure in the range investigated was considerable. High pressure, low temperature preservation of whole blood does not seem to be a promising procedure for long-term mass preservation of whole blood. The presence of 21% ethyl alcohol in the blood permits storage of whole blood at −12 C (+10.4 F) in the liquid state. At this temperature 21% alcohol does not hemolyze red blood cells. The spontaneous hemolysis in blood, kept from freezing by alcohol and dextrose after four months' storage at −12 C, was equal to, or slightly less than, in blood stored at 4 C in A-C-D (anticoagulant acid citrate dextrose) solution alone. Osmotic resistance of the red blood cells showed a definite, but not remarkable, improvement in the blood stored at −12 C in alcohol. It is urged that the use of alcohol for the low temperature, long range storage of blood and other tissues be studied.

Journal of Experimental Medicine, New York

98:291-398 (Oct.) 1953. **Partial Index**

Activation of Profibrinolysin by Antigen-Antibody Reaction and by Anaphylactoid Agents: Its Relation to Complement. G. Ungar, E. Damgaard and F. P. Hummel.—p. 291.

Egestion of Phagocytized Particles by Leukocytes. A. T. Wilson.—p. 305.

Relationship Between Acute Phase Response and Antibody Production in Rabbit. H. F. Wood—p. 311.

Studies of Effect of Bacterial Endotoxins on Rabbit Leukocytes. M. Berthrong and L. E. Cluff.—p. 331.

Inactivation of Herpes Simplex Virus by Phosphatase Enzymes. H. Amos.—p. 365.

Journal-Lancet, Minneapolis

73:305-340 (Aug.) 1953

Meningococcal Disease: Review. R. B. Disenhouse.—p. 305.

Diagnosis and Treatment of Proctologic Disorders. C. A. Neumeister.—p. 313.

Observations on Some Hematological Effects of Cobalt-Iron Mixtures. R. J. Rohn and W. H. Bond.—p. 317.

Rorschach Test and Its Forensic Implications. G. R. Kamman.—p. 325.

73:341-398 (Sept.) 1953

Pulmonary Hypertension. L. E. Wold.—p. 341.

Study of Labor Induction. F. A. Hill.—p. 343.

Transient Cerebral Paralysis. R. M. Fawcett.—p. 346.

Fulminating Meningococcemia with Bilateral Adrenal Hemorrhage. R. B. Tudor and R. R. Kling.—p. 350.

Histoplasmosis in North Dakota. C. C. Smith.—p. 352.

Journal of Nervous and Mental Disease, New York

117:383-478 (May) 1953

Studies on Physiology of Awareness: Correlation Between Intelligence and Anoxemia in Senile Dementia. J. W. L. Doust, R. A. Schneider, G. A. Talland and others.—p. 383.

Value of Ballistocardiography in Neuropsychiatric Hospital: New Application of Method. S. L. Levin and A. G. Selinger.—p. 399.

Streptococci in Etiology of Diverse Diseases, Including Diseases of Nervous System. E. C. Rosenow.—p. 415.

Flickered Light as Provocative Test in Electroencephalography. M. Ostow.—p. 429.

Aspects of Character in Neurotic Veteran. A. F. Valenstein, J. J. Michaels and M. Evje.—p. 445.

*Fatal Cardiac Complications During Electroshock Treatment: Case Report. N. Malamud and A. Zheutlin.—p. 458.

Fatal Cardiac Complication During Electroshock Treatment.—After citing earlier reports on fatalities from electroshock treatment, which has been estimated at 0.5 or 0.8 per 1,000 cases, Malamud and Zheutlin report what they believe to be the first instance of rupture of the heart associated with electroshock therapy. The patient was a 55-year-old woman. Death was obviously due to cardiac tamponade that resulted from bleeding into the pericardial sac produced by the rupture of the myocardium at the site of infarction. Microscopic study indicated that the infarct was approximately of four to six days' duration, and it is, therefore, evident that this lesion antedated the fatal episode. The occurrence of myocardial infarction after electroshock treatment has been explained by Altschule and Tillotson as the result of additional work being required of the heart after the convulsion to overcome the accumulated oxygen debt. This mechanism seemed to play an important causative role in this case in so far as the rupture of the heart was concerned, even though the actual myocardial infarction was the result of coronary occlusion. It has been suggested that the critical period in the course of a myocardial infarction occurs during the second to sixth day when the greatest amount of necrotic tissue is present and the myocardium is the weakest. In this case the combination of weakened myocardium with a four to six day old infarct, plus the increased demand on the heart produced by electroshock probably resulted in the rupture of the myocardium. It is suggested that acute coronary occlusion at a certain critical stage should be regarded as a contraindication to electroshock therapy.

Journal of Nutrition, Philadelphia

51:1-148 (Sept.) 1953. **Partial Index**

Folic Acid Deficiency in the Guinea Pig. C. W. Woodruff, S. L. Clark Jr. and E. B. Bridgeforth.—p. 23.

Studies on Obesity: II. Food Intake and Oxygen Consumption. J. B. Lyon Jr., M. T. Dowling and P. F. Fenton.—p. 65.

Relation of Dietary Protein Levels to Reproduction in the Rat. M. M. Nelson and H. M. Evans.—p. 71.

Distribution of Xanthine Oxidase Factor (Molybdenum) in Foods. W. W. Westerfeld and D. A. Richert.—p. 85.

Utilization of Carotene: I. As Affected by Certain Proteins in Diet of Growing Albino Rats. W. H. James and I. M. ElGindi.—p. 97.

Some Factors Affecting Nitrogen Balance in the Adult Rat. M. Womack, M. W. Marshall and A. B. Parks.—p. 117.

Effect of 3-Nitro, 4-Hydroxyphenylarsonic Acid and Arsanilic Acid on Selenium Poisoning in the Rat. C. Hendrick, H. L. Klug and O. E. Olson.—p. 131.

Journal of the Student A. M. A., Chicago

2:1-84 (Oct.) 1953

Pathogenesis and Treatment of Acute Anuria. I. Snapper.—p. 21.

Carnegie Collection of Human Embryos. G. W. Settle.—p. 24.

Certain Radiological Limitations in Evaluating Diseases of Chest. M. H. Wholey.—p. 28.

Journal of Thoracic Surgery, St. Louis

26:331-440 (Oct.) 1953

Bronchiolar ("Alveolar Cell") Carcinoma of Lung. C. F. Storey, K. P. Knudtson and B. J. Lawrence.—p. 331.

Significance of Pulmonary Hypertension as Cause of Death Following Pulmonary Resection. W. E. Adams, J. F. Perkins Jr., A. Flores and others.—p. 407.

Prevention of Chest Wall Defects: Use of Tantalum and Steel Mesh. D. B. Effler.—p. 419.

An Operation for Chronic Pleural Empyema. F. G. Kergin.—p. 430.

*Emergency Pulmonary Resection for Massive Hemoptysis in Tuberculosis. C. A. Ross.—p. 435.

Emergency Pulmonary Resection for Massive Hemoptysis.—A successful emergency pneumonectomy was performed for massive hemoptysis in a woman aged 45 with pulmonary tuberculosis involving the right lung. On admission of the patient to the sanatorium, one month before the surgical intervention, roentgenograms showed that the upper lobe was fibrotic and contained a large cavity while the lower lobe showed scattered nodule formation and fibrosis. The sputum was positive for Mycobacterium tuberculosis. Resection was considered but postponed because the patient was not considered fit for surgery, and a pneumoperitoneum was induced in an attempt to improve her condition. Several weeks later, after a rather large pneumoperitoneum refill, she began to cough up bright red blood; the hemorrhage became profuse; and for four days she had repeated hemoptyses varying from 10 to 20 oz. of blood at a time. A transfusion of 500 cc. of blood was given. A diffuse spread of the disease to the lower lobe of the right lung was demonstrated on roentgenologic examination. Five days later she had further profuse hemoptysis resulting in extreme shock. Further transfusion was started, but replacement did not keep pace with the continued loss of blood. It was then that the emergency pneumonectomy was performed. She received a total amount of 8,000 cc. of

blood, including the two bottles that were running at the time she was taken to the operating room. Dihydrostreptomycin therapy with a dose of 1 gm. daily was started eight days before the surgical intervention and was continued with reduced doses for four months combined with *p*-aminosalicylic acid in doses of 12 gm. daily. A definite contralateral spread of the disease was noted on the sixth postoperative day. Three weeks after the operation isonicotinic acid hydrazide was started in doses of 200 mg. daily, and combined treatment with this drug and with *p*-aminosalicylic acid was continued for seven months. A solution of *p*-aminosalicylic acid containing 10 gm. of the drug was introduced into the right pleural space every other day for two weeks postoperatively. A small pneumoperitoneum was maintained for five months postoperatively to help reduce the size of the right hemithoracic space. The patient was discharged from the sanatorium after eight months. She was steadily gaining weight, and roentgenograms did not show any evidence of active disease in the contralateral lung. Though the operation was performed during an acute exacerbation of the tuberculous process and on a patient who was a very poor surgical risk, the outcome was gratifying. A contralateral spread of the disease appeared to be controlled by prolonged antibiotic therapy. Technical considerations of importance are as follows: excellent anesthesia is most necessary; large amounts of blood must be given, particularly during the operation; endobronchial tamponade prior to beginning surgery is the ideal method of positively controlling the hazard of aspiration of blood by the other lung; speed in surgery is necessary; prolonged antibiotic therapy is required in addition to surgical intervention. Conservative measures should first be tried to control the situation, but surgery should not be delayed until a massive contralateral spread of the disease has occurred or the patient is in such poor condition as to be beyond surgical help.

Laboratory Investigation, Philadelphia

2:325-396 (Sept.-Oct.) 1953

Studies on Chemical Composition of Normal and Abnormal Blood Vessel Walls: I. Chemical Nature of Vascular Calcified Deposits. D. Carlström, B. Engfeldt, A. Engström and N. Ringertz.—p. 325.
Principles of Rapid Frozen Sectioning, with Method of Prefixation Using Undiluted Formalin at 60 C. L. Reiner.—p. 336.
Autoradiographic Distribution of Intravenous Colloidal Gold (Au^{198}) in Rat. V. A. Stembridge, R. M. Kniseley and W. Gibbs.—p. 349.
Pituitary Changes in Thyroid Aplasia: Possible Significance: Report of Case with Autopsy. A. S. Burt and R. B. Cohen.—p. 357.
New Histologic Technics for Autoradiography. V. H. Witten and V. Holstrom.—p. 368.
Photographing Small Laboratory Animals. V. V. Brunst and R. J. Clayton.—p. 376.
Congenital Malformation of Heart: Interruption of Aortic Arch, Mitral Valve Orifice Atresia, and Persistent Left Superior Vena Cava. E. P. Kintner.—p. 388.

Laryngoscope, St. Louis

63:757-872 (Sept.) 1953. **Partial Index**

Paralytic Stenosis of Larynx: Modification of Intralaryngeal Approach to Arytenoidectomy. B. A. De Bord Jr.—p. 757.
*Trigeminal Symptoms in Acoustic Nerve Tumors. D. Cleveland and J. L. Garvey.—p. 778.
Laryngeal Foreign Bodies with One Case Report. F. L. Harcourt.—p. 786.
Corrosive Esophagitis Due to Nitric Acid. P. H. Holinger, M. J. Tamari and S. H. Bear.—p. 789.
Tonsillectomy and Poliomyelitis. B. Tolczynski.—p. 808.
Hereditary Hemorrhagic Telangiectasis. G. A. Henry.—p. 823.
Critical Evaluation of Noise Audiometry. T. Palva, A. Goodman and I. J. Hirsh.—p. 842.

Trigeminal Symptoms in Acoustic Nerve Tumors.—Analysis of large groups of cases of acoustic nerve tumors and a review of 35 cases observed by the authors reveal that trigeminal symptoms are present in the majority. The authors give a detailed history of one patient in whom the major symptom of facial numbness became so acute and bothersome that surgical removal of a small acoustic neurofibroma was accomplished. If the facial numbness had not been so marked, it is probable that the tumor would have grown much larger before causing other symptoms necessitating or bringing about surgical removal. The presence of facial numbness and particularly corneal anesthesia, as demonstrated by loss of the corneal reflex in association with the symptoms referable to the eighth nerve, should immediately call attention to the probability of the existence of a relatively large tumor in the cerebellar pontine angle on the affected side. Otological examination should seldom fail to establish the diagnosis in the presence of the above mentioned symptoms. The diagnosis and surgical treatment of acoustic nerve tumors in a relatively early stage will lead to a high recovery rate with a minimum of residual symptoms.

Louisiana State Medical Society Journal, New Orleans

105:329-372 (Sept.) 1953

Diagnosis of Pulmonary Lesions. C. Parnall Jr.—p. 329.
Laboratory Diagnosis of Fungus Diseases. D. T. Smith.—p. 340.
Surgical Treatment of Pulmonary Diseases. L. J. O'Neil, V. Kroll and A. Cerniglia.—p. 343.
Strangulation Obstruction: Recent Experimental Work. I. Cohn Jr. —p. 344.
Surgical Treatment of Hypertension. A. Ochsner and C. C. Abbott. —p. 348.
Pulmonary Disease: Diagnosis and Treatment. J. E. Blum.—p. 355.
Hearing and Speech Impairment in Young Children. W. Rubin and J. K. Laguaite.—p. 356.
Functional Headache. F. A. Donaldson and W. L. Waldron.—p. 360.

Michigan State Medical Society Journal, Lansing

52:913-1024 (Sept.) 1953

Arthritis Research in Michigan: IV. Rehabilitation Stressed by Arthritis Foundation. J. J. Lightbody.—p. 946.
Prevention of Rheumatic Fever. Council on Rheumatic Fever and Congenital Heart Disease.—p. 949.
A Morning in an Arthritis Clinic. E. Lipkin.—p. 952.
Electromyographic Diagnostic Methods in Rheumatoid Arthritis. M. K. Newman, A. S. Goldstein and P. Wall.—p. 956.
Gouty Arthritis: Diagnosis and Treatment. J. W. Sigler and D. C. Ensign.—p. 959.
Osteoarthritis Treated with ACTH. M. Dale and M. Amil.—p. 963.
Osteoarthritis of Knee: Importance of Quadriceps Femoris in Mechanism and Management. R. J. Fry and F. B. House.—p. 967.
Heparin and Heparinoid Toxin in Pathogenesis of Hyperfibrinogenemia in Chronic Arthritis. E. A. Peterman.—p. 970.
Effect of Placental Thromboplastin on Hyperfibrinogenemia in Rheumatic Disease. E. A. Peterman.—p. 977.
Clinical Study of Phenylbutazone (Butazolidin) in Various Types of Arthritis. G. E. Platoff.—p. 980.
Subdeltoid Bursitis. K. L. Krabbenhoft and T. Leucutia.—p. 986.

Missouri Medicine, St. Louis

50:739-816 (Oct.) 1953

Lacerations of Face. D. W. Macomber.—p. 755.
Genito-Urinary Injuries. J. C. Cope.—p. 760.
Treatment of Acute Myocardial Infarction. M. Bernreiter.—p. 762.
Technic for Using Suction in Cases of Snake Bite. R. R. Grayson. —p. 763.
Treatment of Periungual Warts. L. K. Halpern and C. W. Lane.—p. 765.
Neurologic Complications of Chronic Alcoholism. L. L. Tureen and A. L. Hahn.—p. 766.

New England Journal of Medicine, Boston

249:471-506 (Sept. 17) 1953

Some Emotional Aspects of Treatment of Diabetes Mellitus and Role of Physician. S. Stearns.—p. 471.
Diffuse Gastric Polyposis: Treatment by Total Gastrectomy. R. T. Doyle, H. E. Nash Jr. and J. H. Graham.—p. 477.
*Clinical Toxicity of Terramycin. F. L. Miller and R. Walker.—p. 479.
Chronologic Account of Meeting Places of Massachusetts Medical Society and Its Council. F. R. Ober.—p. 482.

Toxicity of Oxytetracycline (Terramycin).—Observations on the clinical toxicity of oxytetracycline (Terramycin) were made on 70 tuberculous patients receiving 5 gm. of the drug daily in combination with 2 gm. of streptomycin every third day, both drugs being given for 120 days. In this group, as in a group of 27 treated earlier with oxytetracycline, no ototoxic, nephrotoxic, hepatotoxic, avitaminotic, dermatological, or hematological changes were noted. The signs and symptoms of gastrointestinal tract irritability were the only clinical manifestations of toxicity. Anorexia was the commonest symptom, occurring in 70% of the patients. It usually persisted throughout the four month period of treatment. Nausea, the second commonest symptom, occurred at least once in 50% of the

patients. It was sporadic and transient as a rule. There were four patients, however, in whom nausea was more or less persistent. Vomiting was observed at least once in 9 of the 70 patients studied. In four cases it persisted when 5 gm. was taken. All four patients, 2 of whom were women, were able to continue taking oxytetracycline by either reducing the dosage or taking the drug intermittently. The occurrence of one to four soft stools per day was observed in 70% of the patients, usually throughout the period of therapy. A few of the patients experienced a mild diarrhea. Patients who experienced nausea, vomiting, and diarrhea were examined by proctosigmoidoscopy, but no abnormalities were found. Contrary to many reports in the literature, observations on this series indicated that the gastrointestinal tract irritation due to oxytetracycline is not a serious problem since no patient had to stop taking the drug during the four months of administration, and only four had to have the dosage reduced.

Oklahoma State Medical Assn. J., Oklahoma City

46:235-268 (Sept.) 1953

Resuscitation of Newborn Infant. A. Bloxsom.—p. 237.
Management of Eclampsia. B. C. Chatham.—p. 242.
Causes of Death in Premature Infants. W. T. Newsom and E. F. Stratton.—p. 246.
Hyaline Membrane Disease Pathology, Etiology and Pathogenesis. P. M. Obert.—p. 248.

Review of Gastroenterology, New York

20:697-776 (Oct.) 1953

Method of Increasing Gastric Reservoir Following Total Gastrectomy. B. M. Day and F. Cunha.—p. 705.
Diseases of Stomach and Duodenum. S. Fineman.—p. 714.
Evaluation of Erythrocyte Sedimentation Rate in Gastrointestinal Diseases. E. W. Lipschutz.—p. 725.
Sigmoid Colon Polyp. J. Shaiken.—p. 737.
*Program of Medical Treatment for Chronic Ulcerative Colitis. L. M. Morrison.—p. 744.
X-Ray Diagnosis in Disorders of Biliary Tract. A. J. Tillinghast.—p. 750.

Medical Treatment of Chronic Ulcerative Colitis.—Morrison presents a three point program of medical treatment of chronic ulcerative colitis. It includes: (1) oral administration of salicylazosulfapyridine; (2) oral administration of cortisone or the intramuscular use of corticotropin (ACTH); and (3) psychotherapy. He reviews several previous reports on the use of salicylazosulfapyridine in ulcerative colitis, including his own experience with this drug in 52 patients over a three year period. The dosage was 1.5 gm. (3 tablets) every three hours for two weeks. After a rest of two weeks, the course may be repeated once or twice if needed. The drug is deposited in the connective tissue of the intestine where aminosalicylic acid and sulfapyridine are gradually liberated; it acts locally and then undergoes some absorption into the blood where acetylsulfapyridine and free sulfapyridine are found. The customary measures, such as proper dietary control, rest, supplemental vitamins and palliative drugs, maintenance of fluid and electrolyte balance, are continued during the treatment with salicylazosulfapyridine. Patients who do not respond are then given intramuscular injections of corticotropin in the form of a gel and in doses of 40 to 200 mg. once daily or cortisone by mouth in doses of two tablets (50 mg.) two to four times daily. The majority of patients experience a rather prompt remission with disappearance of the acute inflammatory reaction in the colon, a feeling of well-being associated with improvement in nutritional status, reduction of diarrhea and of bloody stools, and increase in appetite. If a relapse occurs, resumption of the administration of corticotropin or cortisone usually again produces remission. Close observation is necessary during the administration of these hormones because of the danger of serious complications. Most patients with chronic ulcerative colitis need supportive psychotherapy. The patient is encouraged to discuss his life, aggressive feelings, and social difficulties in a series of interviews, the physician playing the role of the sympathetic parent ministering to the patient's needs. These needs arise from insecurity and oversensitivity, aggravated by the debilitating effects of chronic abdominal pains, diarrhea, and bloody, purulent stools.

Stanford Medical Bulletin, San Francisco

11:137-202 (Aug.) 1953. **Partial Index**

Complete Arterialization of Liver Blood Supply: Part 2: Reciprocal Relationship of Portal Venous and Hepatic Artery Flow. R. Lee, W. Goggans and R. Cohn.—p. 137.
Use of Triphenyl Tetrazolium Chloride as Supravital Stain in Chemotherapeutic Trials with Ehrlich Ascites Tumor. F. A. Brown Jr.—p. 139.
Neutropenia Following Injection of Mercuhydrin®: Report of Case. A. Z. Cerf.—p. 154.
*Atabrine® and Chloroquine in Treatment of Chronic Discoid Lupus Erythematosus: Preliminary Report. E. M. Farber and I. E. Driver. —p. 157.
Biological Activity of Ehrlich Ascites Tumor Cells Cultured on Glass Substrates. L. Kolb and B. V. Siegel.—p. 159.
Splenosis—Autotransplantation of Splenic Tissue: Critical Review and Report of New Case Mistaken for Endometriosis. J. W. Hartman. —p. 162.
Aplastic Anemia During Pregnancy. T. W. Loring.—p. 170.
Clinical Importance of Hepatic Involvement in Sarcoidosis. H. J. Zimmerman.—p. 173.
Surgical Treatment of Abdominal Aortic Aneurysms: Report of Case Treated by Resection of Aneurysm with Restoration of Aorta by Homograft. F. Gerbode, H. Parsons and I. Affonso da Costa.—p. 179.
Sensitivity of Various Clinically Important Bacteria to Four Antibiotics: Results Obtained with Plate-Screening Method. L. A. Rantz and H. H. Rantz.—p. 183.
Experimental and Clinical Data with D-Glucuron Isonicotinyl Hydrazone in Treatment of Tuberculosis: Preliminary Report. C. Brown, J. L. Gompertz, I. Gourly and E. G. Roberts.—p. 188.

Treatment of Chronic Discoid Lupus Erythematosus.—Fourteen patients with chronic discoid lupus erythematosus were treated, 10 receiving quinacrine hydrochloride and 4 chloroquine phosphate. The dosage of quinacrine hydrochloride consisted of 300 mg. daily for the first week, 200 mg. daily for the second week, and 100 mg. daily for the third week, until objective improvement in the lesions appeared. The first dose of chloroquine phosphate was 300 mg.; this was repeated after 6 hours and then after another 12 hours. Later it was given in 150 mg. doses three times a week. Of the 10 patients receiving quinacrine, 6 showed definite improvement, 3 slight improvement, and 1 a progression of the lesions. In four patients receiving chloroquine, one showed slight improvement and 3 little or none. The time elapsed is too short to predict how long the clinical remission will be maintained. The mode of action of quinacrine may be explained in one of three ways: (*a*) reduction in light sensitivity of the skin; (*b*) an action similar to that of corticotropin and cortisone, or (*c*) by antagonizing adenyl compounds in the chronic discoid lupus erythematosus lesions.

Surgery, Gynecology and Obstetrics, Chicago

97:401-528 (Oct.) 1953

Surgical Treatment of Epithelial Tumors of Parotid Gland. R. W. Buxton, J. H. Maxwell and A. J. French.—p. 401.
*Pulmonary Resection in First Year of Life. E. S. Crossett and R. R. Shaw.—p. 417.
Recognition and Treatment of Arteriosclerotic Stenosis of Major Arteries. E. J. Wylie and J. S. McGuinness.—p. 425.
Relationship of Vitamin C and ACTH in Experimental Wounds. J. A. Schiling, M. Radakovich, B. V. Favata and others.—p. 434.
Experimental and Clinical Evaluation of Surgical Suture Materials: II. E. T. Madsen.—p. 439.
Intraperitoneal Administration of Terramycin in Treatment of Experimental Peritonitis. W. E. Schatten and W. E. Abbott.—p. 445.
Thiopental, Curare, and Nitrous Oxide Anesthesia for Cesarean Section with Studies on Placental Transmission. E. N. Cohen, W. J. Paulson, J. Wall and B. Elert.—p. 456.
Prevention of Gas Explosions in Large Bowel During Electrosurgery. G. I. Becker.—p. 463.
Biliary Tract Surgery in Aged Patient. E. L. Strohl and W. G. Diffenbaugh.—p. 467.
*Evaluation of Shunt Operation for Portal Decompression. E. J. Jahnke Jr., E. D. Palmer, V. M. Sborov and others.—p. 471.
Roentgenography of Cysts of Breast. J. Gershon-Cohen and H. Ingleby. —p. 483.
Postabortal Sepsis Due to Clostridium Welchii. G. W. Douglas, B. H. Carney and D. Pethillo.—p. 490.
Effects of Apresoline, Veratrum Alkaloids, High Spinal Anesthesia, and Arfonad on Renal Hemodynamics of Pregnant Patients with Toxemia and Essential Hypertension. S. A. Kaplan and N. S. Assali.—p. 501.
*Carcinoma of Breast: Results, Evaluation of X-Radiation, and Relation of Age and Surgical Castration to Length of Survival. G. V. Smith and O. W. Smith.—p. 508.

Pulmonary Resection in First Year of Life.—Pulmonary resection was performed on six infants between the ages of two and eight months. Three had congenital pulmonary cysts for which lobectomy was performed in two and local resection in

one; one had chronic, irreversible atelectasis; and two had bronchiectasis associated with cystic pancreatitis. In a seventh infant reported on previously by one of the authors, a right middle lobectomy was done because of localized hypertrophic emphysema. A five to six month follow-up of the three patients with cystic disease showed that the infants were developing normally with no evidence of respiratory difficulty. A follow-up was unobtainable in the case of the infant with atelectasis. A six week follow-up of the patient with localized hypertrophic emphysema showed normal expansion of the right lung and normal position of mediastinum. Although resection of the atelectatic and bronchiectatic lobes failed, in the remaining two patients, to improve the pulmonary complications associated with cystic pancreatitis sufficiently to bring about a long survival, it is believed that pulmonary resection is rational in this condition. With the advances made in anesthesia, technique of pulmonary surgery, antibiotics, and the knowledge of respiratory physiology, it is now possible to perform pulmonary resections in infants with a high degree of safety.

Shunt Operation for Portal Decompression.—Of 30 patients with portal hypertension and esophageal varices operated on, the causative obstruction of the portal bed was intrahepatic in 28, Laennec's cirrhosis in 21, postnecrotic cirrhosis in 6, and biliary cirrhosis in 1; extrahepatic block accounted for portal hypertension in only 2 patients with Banti's syndrome. Regardless of the exact mechanism responsible, some type of portal decompression must be utilized, if rupture of esophageal varices causing massive hematemesis with resulting deaths in as many as 70% of all patients with portal hypertension are to be prevented or significantly decreased. The direct end-to-side portacaval shunt is the operation of choice and was employed in 22 patients. The splenorenal shunt was established in five patients. Neither shunt could be established in the remaining three patients, and less desirable procedures were utilized. A thoracoabdominal incision was used exclusively. The Potts coarctation clamp and the Potts giant bulldog clamp are recommended for use on the portal vein and inferior vena cava respectively. Only two of the 30 patients died postoperatively, and both deaths occurred from liver failure. The alterations in postoperative liver function were mild, lasting from 7 to 10 days, when the operative time was minimal and intravenous chlortetracycline (aureomycin) was used routinely. Complete diversion of the portal blood did not interfere with the hepatic function in patients followed up to three years. Preoperative and postoperative manometric pressure readings in the esophageal varices are recommended in all patients to evaluate the operation. These pressures correlated closely with those obtained in the portal vein before and after operation. The portal circulation time, obtained by using the ether technique, indicated patency of the shunt and also correlated with the various pressure readings. Studies indicated that the systemic caval pressure influenced the degree of portal decompression obtained after operation. With follow-up from one month to three years, only two minor hemorrhages occurred after adequate portal decompression. Shunt operation was employed in six patients with severe portal hypertension and esophageal varices who had not had any previous episode of hemorrhage; there were no postoperative hemorrhages in the group. Percutaneous splenic and portal venography offered valuable diagnostic aid in determining the configuration of the portal vein prior to surgical intervention and in determining the patency of the shunt postoperatively.

Carcinoma of the Breast.—The results of simple and radical mastectomy with and without primary x-ray therapy in 739 consecutive and unselected women treated between 1905 and 1946 and followed up for from 5 to 20 years were subjected to critical analysis concerning the relationship of primary x-ray therapy, age at the time of surgical intervention, and prophylactic castration to the length of survival. According to these analyses, primary x-ray treatment in conjunction with mastectomy had prolonged the life among patients with axillary metastases. From a separate study of patients with grade 2 and grade 3 cancers of the breast, evidence was obtained that only patients with grade 3 tumors were benefited by x-ray therapy. In this group, moreover, the higher rates of survival were observed not only among those with involvement of axillary nodes but also among those without such involvement. The lowest percentages of survivors were among women between the ages of 40 and 60, that is, during the premenopausal and postmenopausal climacteric, suggesting that changes referable to the physiological involution of the ovaries augment the clinical malignancy of mammary cancer. Prophylactic ovariectomy prolonged life not only in women less than 40 years of age and over 59 but more so in those 40 to 59 years of age. There was some evidence of lengthened survival from prophylactic x-ray irradiation of the ovaries. The improved percentages of survival among the patients subjected to prophylactic ovariectomy were high enough to indicate that prophylactic ovariectomy deserves more extensive trial in women up to 70 years of age with axillary metastases if they can be persuaded to undergo a second major operation; the amount of benefit in each patient is as yet unpredictable. If, however, the growth of a given cancer of the breast should be amenable to retardation by the removal of ovarian stimulation, it would seem that the earlier ovariectomy is performed the longer will be survival. The authors' statistical analyses are given as suggestive but not conclusive evidence in favor of the findings.

Yale Journal of Biology and Medicine, New Haven

26:1-106 (Sept.) 1953. **Partial Index**

Role of Alcohol in Pathogenesis of Cirrhosis. G. Klatskin.—p. 23.

Sensitivity to Cold in Hereditary Obese-Hyperglycemic Syndrome of Mice. J. Mayer and R. J. Barrnett.—p. 38.

Formation of Tetanus Antitoxin by Spleen and Lymph Node Intraocular Transplants. W. M. Hale and R. D. Stoner.—p. 46.

Regulation of Food Intake in Normal Rats and in Rats with Hypothalamic Hyperphagia. J. L. Strominger, J. R. Brobeck and R. L. Cort.—p. 55.

*Fraction of Commercial Yeast Which Protects Against Bacterial Infection: Preliminary Note. I. A. Parfentjev.—p. 75.

Fraction of Yeast That Protects Against Bacterial Infection.—There are indications that vaccination with Hemophilus pertussis, while increasing resistance against infection by this organism, will, at the same time, produce hypersensitivity to the H. pertussis antigen. Such sensitivity, however, is not specific for pertussis but crosses with several other species of gram-negative bacteria. Furthermore, mice immunized against pertussis are much more susceptible to infection by other gram-negative bacteria than are their normal litter mates. Apparently, specific immunization can produce a nonspecific lowering of resistance that predisposes the host to unrelated infections. Because bacterial protein plays a part in hypersensitivity and is implicated in the etiology of infections, the search for a desensitizing protein was undertaken. The obvious selection was protein associated with the nucleic acid of the bacterial cell from the specific Hemophilus organism. Injection of this material reinforced the resistance of sensitized animals. However, since hypersensitivity is not species specific, the possibility of another source of comparable material was apparent, and it was found that a preparation of yeast sodium nucleate would not only reduce the hypersensitivity of vaccinated animals to the same pertussis antigen, but make them refractory to gram-negative bacteria. Numerous experiments proved that mice after injection with sodium nucleate are protected against infection by Proteus, Pasteurella, Brucella, and Escherichia coli organisms. Subsequent studies indicated that different brands of sodium nucleate were variable in potency. The source material, yeast, was fractionated in search of the active principle. A very potent fraction was isolated from baker's yeast, which is over three-hundred-fold more effective than commercial preparation of sodium nucleate and will protect animals against infection with gram-negative bacteria.

FOREIGN

Acta Neurologica et Psychiatrica Belgica, Brussels

53:487-548 (Aug.) 1953

Remarkable Effects of Treatment of Cerebral and Other Thromboses with Sulfonamides and Antibiotics. A. Leroy and R. Leroy.—p. 487.
Thrombotic Disease Greatly Improved by Sulfonamide Therapy Followed by Convulsion Therapy. R. Leroy.—p. 491.
Pathogenesis and Biological Treatment of Nervous Disorders Said to Be Functional: Precedence and Superiority of Cutaneous Allergic Shock with Tuberculin. M. Molhant.—p. 494.
*Histopathology of Multiple and Diffuse Sclerosis in Man and Animals. J. Hallervorden.—p. 517.
Use of Phenylethylacetylurea in Treatment of Epilepsy. L. Sorel and R. De Smedt.—p. 531.

Histopathology of Multiple and Diffuse Sclerosis.—Multiple sclerosis in its diverse forms is an encephalitis marked by foci of specific demyelinization affecting the myelin sheaths, the axons and neurons being spared. The foci arise by diffusion of a myelinolytic substance from small blood vessels or from tissue liquids without regard to preexisting structures. The foci are distributed throughout the nervous system in general, although areas of predilection can be found. There are simple and concentric foci. Some surprising analogies have been found between human multiple sclerosis and the ringspot diseases of plants. 1. Both display the same kind of concentric foci, the same kind of simple continuous foci, and the combination of the two types. 2. These foci arise by simple or rhythmic diffusion of a constantly multiplying agent of infection; in plants, this agent has been proved to be a virus. 3. The concentric arrangement of the foci is thought to be due to the repeated appearance of intratissue defensive substances. Substances hostile to the virus have been isolated in afflicted plants. 4. In both diseases the foci are distributed haphazardly throughout the organism, but also have areas of preference. 5. Distribution is achieved by way of the parenchyma and vessels in both and is comparable in terms of time and space. The agent of infection can pass through only the smaller vessels, which, incidentally, it does not attack. 6. The disease is associated, in either case, with a particular tissue and thus with a particular organ. There appears to be no connection between multiple sclerosis and any of the other encephalitic diseases. Experimental allergic encephalitis does not show specific demyelinization and so cannot be compared to multiple sclerosis. Among the spontaneous diseases of this type in animals, only multiple sclerosis in the dog has histopathological characteristics suggestive of human multiple sclerosis.

Anales de la Facultad de Medicina, Montevideo

38:75-162 (March-April) 1953

*Necrotic Arachnidism. J. E. Mackinnon and J. Witkind.—p. 75.
Tolerance to Glucose in Extrapyramidal Syndromes. E. Balea, J. P. Segundo and C. Mendilaharsu.—p. 101.
Anuria: Biology and Pathogenesis. J. Lockhart.—p. 105.

Necrotic Arachnidism.—Necrotic arachnidism consists of a cutaneous necrosis, progressing to dry gangrene at the site of the bite, fever, jaundice, hemoglobinuria, cutaneous and intestinal hemorrhages, exanthema, and hemolysis. It is a serious condition and is fatal in a high percentage of children. A spontaneous regression of the acute symptoms occurs between the fifth and seventh days; local necrosis follows a slowly regressive course. From 1938 to 1949, 29 cases have been reported in the Uruguayan literature; the authors add three new cases. The disease was acute in eight patients. Three patients were children between the ages of 6 and 11 years. Two died 30 and 36 hours after the bite. The spiders were captured in the act of biting in two cases. They were identified as females of the Loxosceles laeta species. In the remaining cases the spider was either killed by the family of the victim or its type was not mentioned by the authors. Loxosceles laeta spiders are common in certain cities of Uruguay and other countries of South America. Their bite produces the necrotic, eruptive, and icterohemolytic forms of arachnidism. The authors made experiments on a large number of Loxosceles laeta spiders with the following results. Mice usually die within 24 hours after the bite or after a subcutaneous injection of the poison. They die with symptoms of general poisoning and paralysis of respiration. Rabbits usually die within 24 hours after the bite or after the subcutaneous or intradermic injection of the poison. They die with symptoms of general poisoning. The bites of one or two spiders are necessary to cause death in rabbits, according to the weight of the animal. Degeneration of the hepatic and renal cells and necrosis of the epithelium of the large intestine were observed in mice. The fatal dose of the poison is very close for mice and rabbits. In guinea pigs, the necrotic local lesion is the only effect observed. The female Loxosceles laeta, and not the male spider, proved to be the one that caused death of mice and rabbits and the one that contains in its glands enough poison to kill four or five mice or rabbits. The serum of immunized rabbits proved to protect mice against at least one mortal dose of the poison, even if the serum was given to the animal four hours after inoculation of the poison. The serum of nonimmunized rabbits and other antiarachnid and antiophidic serums did not protect mice against the poison. Prevention of necrotic arachnidism depends on cleanliness of housing and the use of benzene hexachloride as an insecticide.

Ärztliche Wochenschrift, Berlin

8:945-968 (Oct. 2) 1953. **Partial Index**

Animal Experiments on Sensitivity of Tubercle Bacilli to Amithiozone (Conteben). G. Veltman.—p. 951.
*Experiences with the Chemical Pregnancy Test According to Schlör. D. Benthin and H. v. Törne.—p. 957.
Importance of Syphilis During Pregnancy. H. Möbest.—p. 959.

Experiences with Chemical Pregnancy Test.—According to Benthin and von Törne attempts to demonstrate pregnancy by chemical means have not been convincing. This applies to the histidine method, as well as to the pregnanediol test. The iodine boiling test of Schlör seemed to be somewhat superior to these tests, not only in reliability but even more in simplicity. The authors, in performing the biological Galli Mainini test, which utilizes male toads, on 145 urines submitted to them for pregnancy tests, also made Schlör's chemical test on the same urines. The Schlör iodine boiling test yielded 17 negative reactions in 74 established pregnancies (23%) and 14 positive reactions in 71 urines (20%) of nonpregnant women. These percentages of erroneous reactions correspond closely to those obtained by others with the Schlör test. The authors conclude that the iodine boiling test cannot be regarded as a reliable indicator of pregnancy. Modifications of the original method did not noticeably improve the results.

Australian J. Exper. Biol. and M. Science, Adelaide

31:291-424 (Aug.) 1953. **Partial Index**

Insulin Tolerance and Hypoglycaemic Convulsions in Sheep. I. G. Jarrett and B. J. Potter.—p. 311.
Studies on Pathogenicity for Adult Mice of Virus Isolated from Case of Pleurodynia. J. K. Dineen and R. A. Barter.—p. 337.
Preparation and Properties of an Inhibitor of Influenza Virus Haemagglutination from Human Meconium. C. C. Curtain, E. L. French and J. Pye.—p. 349.
Back-Recombination of Influenza A Strain Obtained in Recombination Experiments. P. E. Lind and F. M. Burnet.—p. 361.
*Ammonia, Urea and Uric Acid Content of Toenails in Renal Insufficiency and Gout. A. Bolliger and R. Gross.—p. 385.
Studies on Soluble Complement Fixing Antigen of Influenza Virus: II. Serological Behavior of Antigen. G. L. Ada, B. T. Perry and J. Pye.—p. 391.
Effect of Noradrenaline-Induced Systemic Vasoconstriction on Formation of Pulmonary Oedema. P. I. Korner.—p. 405.

Ammonia, Urea, and Uric Acid in Renal Insufficiency and Gout.—The toenails of 11 patients with various types and degrees of renal impairment, but all with markedly increased blood urea levels at the time of death, were examined for water extractable urea, ammonia, and uric acid. The urea content of these toenails was always elevated. The ammonia content did not exceed normal values. The uric acid content of the toenails was markedly elevated in patients with chronic nephritis, but it was normal in those with renal impairment of short duration. In a patient with long-standing severe gout who died from

interstitial nephritis, the uric acid content of the toenails was about four times as high as that from normal persons. For the estimation of the nonkeratin uric acid content, 50 mg. of nail are required; this amount can readily be obtained by means of nail parings from living subjects. Thus, it became possible to evaluate the uric acid content of toenails and fingerails and of head hair of three patients suffering from gout uncomplicated by renal insufficiency. They all showed definitely increased uric acid values in nails and head hair, while the blood uric acid content was normal at the time. This observation suggests that uric acid determinations on the readily available keratinous appendages and particularly toenails may be of diagnostic value. The elevated uric acid values found in gout, and to a lesser extent in chronic renal insufficiency, could be due either to a spilling over from other tissues into the keratinous structure as such or, in part, at least to a metabolic disturbance within the keratin-producing structures. The deposition in the keratinous structures of uric acid, which is difficult to excrete when there is renal impairment, seems feasible, particularly since the capacity of keratinous tissues to contain or fix comparatively large amounts of uric acid has been demonstrated in other mammals. In nephritic persons, uric acid formed as an end-product of the nucleic acid degradation in the process of keratinization may thus be forced into the developing keratin to a greater extent than usual. In advanced gout, moreover, considerably higher uric acid values can be obtained in toenails and hair than in chronic nephritis, though the blood uric acid levels are about the same in the two conditions. The authors are inclined to favor the view that increased deposition in gout is not due to a metabolic disturbance in the keratin-producing structures but that it is simply an excretory mechanism.

British Journal of Ophthalmology, London

37:577-640 (Oct.) 1953. **Partial Index**

Anatomical Study of Schlemm's Canal and Aqueous Veins by Means of Neoprene Casts: III. Arterial Relations of Schlemm's Canal. N. Ashton and R. Smith.—p. 577.
Changes in Refraction During Life. M. Bücklers.—p. 587.
Age Distribution of Onset of Esotropia. W. Nordlöw.—p. 593.
Histopathological Examination of Bilateral Symmetrical Cyst of Retina. J. Francois and M. Rabaey.—p. 601.
Binocular Vision of Miners with Nystagmus. A. Smith and R. C. Browne.—p. 609.
Primary Glaucoma Amongst Gold Coast Africans. J. W. R. Sarkies.—p. 615.
Grattage in Treatment of Trachoma. S. A. Quadeer.—p. 621.
New Method of Slit-Lamp Micro-Ophthalmoscopy. G. E. Bayadi.—p. 625.

British Journal of Physical Medicine, London

16:177-198 (Sept.) 1953

Focal Ultra-Violet Therapy in Physical Medicine Department. J. B. Stewart.—p. 177.
Notes on Measurement and Dosage of Ultra-Violet Radiation. H. Morris.—p. 180.
Kromayer Lamp. G. H. Dobney.—p. 183.
Frozen Shoulder (Scapulo-Bicipital Syndrome). A. Farkas.—p. 187.
*Relaxation of Muscle Spasm in Chronic Arthritis by Prostigmin. T. H. Howell.—p. 192.

Prostigmin for Muscle Spasm in Arthritis.—One of the common syndromes among the elderly persons under treatment at a clinic for rheumatic disorders appeared to be pain associated with muscular spasm. This was found in osteoarthritis and in rheumatoid disease. The usual sites were: (1) the vastus internus muscle, secondary to arthritis of hips or knees; (2) the flexor muscles of the forearm, associated with changes in the carpus or the elbow; and (3) the trapezius muscle, often accompanying cervical spondylitis. A series of 60 outpatients, all of whom had pain from muscle spasm in one of the sites mentioned above, were given 0.5 mg. of the drug by intramuscular injection. In 38 of these, one injection was enough to relax the muscles and to relieve the pain. Among the remaining patients, 14 received two or more injections with benefit, whereas the other 8 either did not respond or were made so sick by the drug that they could not recall any relief. Only pain from muscle spasm was relieved by prostigmin; other types remained unaltered. Prostigmin was tried also in 12 patients with chronic arthritis. An injection of 0.5 mg. was given twice a week before remedial exercises, in addition to its therapeutic use for spasm. The increased freedom of movement resulting was considerable, so that the patients themselves would deliberately ask for their injections "to make them looser." The effect of the drug lasted as a rule for 8 or 12 hours and began about 20 minutes after intramuscular injection. A tendency to vomiting or abdominal discomfort is an undesirable side-effect, and seems to increase when the drug is used over long periods.

British Journal of Surgery, Bristol

41:1-112 (July) 1953. **Partial Index**

*Pulmonary Adenomatosis. H. E. Hutchison and K. Fraser.—p. 1.
Gall-Stone Ileus. P. J. M. Wright and P. A. Trafford.—p. 6.
Note on Treatment of Central Dislocation of Hip-Joint. A. B. Watson.—p. 9.
Ventriculographic Changes in Cysticercosis of Brain. D. G. Reddy and B. Ramamurthy.—p. 11.
Congenital Archenteric Cysts. J. Hutchison and J. D. Thomson.—p. 15.
Argentaffin Carcinomata with Special Reference to Growths of Ileocaecal Valve. H. Le Brun.—p. 20.
*Percutaneous Transhepatic Cholangiography in Diagnosis of Obstructive Jaundice. A. W. Nurick, D. H. Patey and C. G. Whiteside.—p. 27.
Chronic Lymphoedema of Extremities and Its Management. J. Watson.—p. 31.
Persistence of Foetal Structures in Pyelonephritic Kidneys. A. G. Marshall.—p. 38.
Plasmocytomas Producing Paraplegia. L. Rodgers.—p. 54.
Perforation and Obstruction by Enterolith Complicating Jejunal Diverticulosis: Report of Three Cases. N. S. Slater.—p. 60.
Fat Embolism, with a Report of Nine Cases. A. J. Alldred.—p. 82.
Acute Osteomyelitis in Infancy and Early Childhood. T. James.—p. 87.
Attempt to Produce Peptic Ulcer by Phrenic-Vagus Anastomosis in Dogs. T. S. Heslop, B. Schofield, W. T. Catton, D. E. Wright and P. A. Burstall.—p. 92.

Pulmonary Adenomatosis.—The first case of pulmonary adenomatosis in the United Kingdom to be diagnosed before death occurred in a 36-year-old woman who had complained of lassitude six months before she was seen by the authors at the Hairmyres Hospital in Glasgow. She had had an attack of what was presumed to be pneumonia a month after the onset of the lassitude. The only symptom of diagnostic value was the expectoration of abundant frothy sputum. In the lobectomy specimen taken from her right lung, the disease was present in the form of multiple nodules that had coalesced to produce almost uniform involvement of the lower and medial parts of the lobe. There was no invasion of the pleura, and microscopic examination disclosed a highly differentiated epithelial neoplasm of pronounced papillary architecture and only very restricted powers of replacing the normal lung structures. Mucin formation was not a pronounced feature of the growth. After operation, the remaining portion of the right lung became involved and the disease spread to the left lung. The patient became increasingly more dyspneic and died at home six months after operation. A necropsy was not permitted, and thus the possibility of an extrapulmonary lesion was not conclusively ruled out. The clinical features and natural history of the case, however, are in keeping with descriptions in the literature and justify the diagnosis of pulmonary adenomatosis.

Percutaneous Transhepatic Cholangiography.—In this series of five patients with obstructive jaundice on whom percutaneous transhepatic cholangiography was performed by the injection of 20 ml. of 35% iodopyracet (Diodone) into a bile duct, the procedure was technically successful and clinically noncontributory in four. One patient, in whom the procedure was also technically successful, died from blood and biliary leakage into the peritoneal cavity; this fatality is attributed to failure in preparing the patient for the test with vitamin K. The radiographs obtained by this method were good and permitted a correct diagnosis. In three patients without obstructive jaundice, the procedure was unsuccessful. The authors feel that their method is valuable and should be investigated further, despite the one death. The test ought not to be any more hazardous than liver biopsy, which has been successfully performed a great many times and which requires a larger needle.

British Medical Journal, London

2:683-734 (Sept. 26) 1953

Field Survey of General Practice, 1951-1952. S. J. Hadfield.—p. 683.
Practitioner and Hospital Service. H. Ogilvie.—p. 707.
General Practice and the Hospital. J. G. M. Hamilton.—p. 711.

2:735-786 (Oct. 3) 1953

Treatment of Cancer of Larynx by Interstitial Radium Needles. W. D. Harmer.—p. 735.
Folic-Acid-Excretion Studies in Investigation of Malignant Disease. R. H. Girdwood.—p. 741.
Prevalence of Foot Defects Among Wartime Recruits. D. Hewitt, A. M. Stewart and J. W. Webb.—p. 745.
Incidence, Origin, and Prevention of Certain Foot Defects. D. A. Craigmile.—p. 749.
17-Hydroxycorticosterone Content of Human Ascitic Fluid. C. L. Cope and B. Hurlock.—p. 753.
Piperazine in Treatment of Threadworms in Children: Report on Clinical Trial. R. H. R. White and O. D. Standen.—p. 755.
Experimental Chemotherapy of Oxyuriasis. O. D. Standen.—p. 757.
Vaginal Ulceration Due to Potassium Permanganate. E. A. J. Ament and C. S. Nicol.—p. 759.
Pregnancy and Gaucher's Disease. Y. M. Bromberg, R. Toaff and D. Dengott.—p. 761.
Use of Electrodermatome, with Special Reference to Its Value in Serious Burns. P. Clarkson and D. A. C. Reid.—p. 763.

2:787-840 (Oct. 10) 1953

*Carcinoma of Female Breast: Conservative and Radical Surgery. I. G. Williams, R. S. Murley and M. P. Curwen.—p. 787.
*Treatment by Oestrogens of Pulmonary Metastases from Breast Cancer. B. A. Stoll and F. E. Ellis.—p. 796.
Ten Years' Clinical Experience of Modified Leucotomy Operations. W. Sargant.—p. 800.
Anal Fissure. E. S. R. Hughes.—p. 803.
Intestinal Protozoa in Mentally Deficient Children. G. D. Belios and W. Cooper.—p. 805.
Hypercalcaemia and Impairment of Renal Function in Generalized Sarcoidosis. C. E. Dent, F. V. Flynn and J. D. N. Nabarro.—p. 808.
Splenic Venography. N. R. Konar and A. N. Sen Gupta.—p. 810.

Carcinoma of the Female Breast.—An analysis is made of 1,044 cases of carcinoma of the breast in women first seen at the same hospital in the period 1930-1939. Since these patients were treated some time ago, follow-ups permit a comparison of the treatments employed. Simple surgery was undertaken in 229 cases, more than half of which were treated by simple excision of the tumor. Radical mastectomy was done in 338 cases, and a modified radical operation in 167. Radium treatment without surgery was used in 149, and x-rays alone in 114. Forty-seven cases remained untreated. Of the patients treated surgically, about two-thirds were also given irradiation. This type of treatment became more frequent toward the end of the period mentioned; at the same time x-rays tended to replace radium, particularly in combination with simple surgery. The 5 year survival rate for lesions treated in stage 1 was 72%; the 10 year rate 51%; the 5 year rate for stage 2 lesions was 39% and the 10 year rate 26%. The rates for each treatment group showed no appreciable departure from these figures despite the fact that simple surgery consisted merely of local excision in more than half the cases. The addition of irradiation did not affect the rates, although it is possible that selection of cases may have concealed some of the benefits of radiotherapy. Attention is drawn to the lower survival rates in the lesions assessed clinically to be in stage 2 but with axillary nodes uninvolved as compared with stage 1 lesions with nodes involved. The mortality of radical mastectomy was 1.2%. Edema of the arm occurred after radical surgery in 14% of the patients, compared with 5% after simple surgery. It was almost twice as frequent when the radical wound gave rise to complications as in those with primary healing. The most impressive finding in this series is the remarkable similarity in survival rates after different methods of treatment. All methods have been equally effective in stages 1 and 2; but all seem to be equally ineffective in prolonging life. It is not known to what extent treatment affected survival. A general conclusion from these data is that, where efficient radiotherapy is available, radical mastectomy should be abandoned in favor of conservative surgery.

Pulmonary Metastases from Breast Cancer.—The histories of 61 patients with pleural and lung metastases from carcinoma of the breast for whom estrogen therapy was prescribed are compared to those of 66 for whom it was not. In the treated group, 31% (19) of the patients survived over 12 months as compared with 7.5% (5) in the untreated group. In the treated group, 26% (16) of the pulmonary lesions showed regression, compared with none in the untreated group. Thirty-nine patients took estrogen for three months or more; 22 (57%) survived seven months or longer. Twenty-two took estrogen for two months or less; 4 (18%) survived over seven months. It may be that results are better with a more prolonged administration of estrogen; but regression occurred in some cases after administration of estrogen for two months. It must be assumed, therefore, that two months is adequate for the establishment of a reaction capable of controlling the disease. The effects of estrogen in these cases are essentially temporary, and no prophylactic effect against the development of pulmonary metastases can be shown.

Bruxelles Medical, Brussels

33:1901-1952 (Sept. 20) 1953

Physiopathology of Arterial Hypertension. F. Reubi.—p. 1909.
*Role of Liver in Metabolism of Estrogenic Bodies. C. Mayer.—p. 1925.

Role of Liver in Metabolism of Estrogenic Bodies.—The fact that the metabolism of estrogens depends on the liver, an antiestrogenic organ affecting both natural and synthetic substances, is shown by various experimental data. Inactivation of estradiol, an ovarian hormone, is accomplished by the liver. It is transformed into estrone and a very weak hormone, estriol. Much more estriol than estrone is produced. The chemical transformation of estradiol into estriol is irreversible. This knowledge illuminates the clinical manifestations designated by the term "hepato-ovarian syndrome." The syndrome is present in patients with hyperfolliculinism caused by hepatic dysfunction. Awareness of this interdependent relationship should caution against the indiscriminate use of natural and synthetic estrogens that has resulted from the popularity of these hormones in recent years.

Canadian Medical Association Journal, Montreal

69:197-348 (Sept.) 1953

Peptic Ulcer. J. A. MacFarlane and J. D. Mills.—p. 233.
Post-Gastrectomy Syndrome. J. D. Mills.—p. 237.
Prepyloric Exclusion in Operation of Gastrectomy for Duodenal Ulcer—Bancroft Procedure. J. D. Mills and W. J. McCracken.—p. 242.
Palliative Treatment of Prolapse of Uterus. S. Gold.—p. 245.
Five Year Survey of Multiple Pregnancies. R. C. Ross and N. W. Philpott.—p. 247.
Rectal Tribrom-Ethanol (Avertin, Bromethol) in Eclamptic Toxaemia. W. D. Frew.—p. 254.
Concerning Strokes. M. Fisher.—p. 257.
After Effects of Western Equine Encephalomyelitis Infection in Man. J. S. Fulton and A. N. Burton.—p. 268.
Primary Peritonitis. J. A. Ryan.—p. 272.
Treacher Collins Syndrome. J. Szlazak.—p. 274.
*Haemorrhage in Anticoagulant Therapy. R. L. MacMillan and K. W. G. Brown.—p. 279.
*Isoniazid in Childhood Tuberculosis. G. Boyd, T. E. Roy and A. Josiukas.—p. 283.
Report on Survival of Patients Treated for Cancer from 1935 to 1947 Inclusive. N. A. McCormick.—p. 288.
Two Cases of Unilateral Blindness Following Anaesthesia with Vascular Hypotension. J. G. Gillan.—p. 294.
Blood Vessel Surgery. G. Murray.—p. 296.
Experience in Pulmonary Resection for Tuberculosis. E. Harrison, G. D. Saxton and W. J. McLaren.—p. 299.
*Tuberculosis of Superficial Lymph Nodes. G. L. Gale.—p. 303.
Treatment of True Widening of Ankle Mortise. P. G. Costigan.—p. 310.

Hemorrhage During Anticoagulant Therapy.—One of four anticoagulants was assigned by random distribution to 489 patients with thromboembolic disorders treated at the Toronto General Hospital. Of the 489 patients, 112 were given heparin (10,000 units per cubic centimeter) intramuscularly. The usual dose of heparin was 150 mg. (1.5 cc.), and this was injected into the gluteal muscles every 12 hours. Maximal prolongation of the clotting time occurred within 3 to 4 hours, with a return to normal in 8 to 10 hours. Hemorrhagic complications occurred in 17 of these 112 patients. Bishydroxycoumarin (Dicumarol) was given by mouth to 123 patients; hemorrhagic complications occurred in 4. Phenindione (Phenylindanedione) was given orally to 133 patients; bleeding did not occur in any of these. Cyclocumarol was given orally to 121 patients, and hemorrhagic complications occurred in 7.

Thus 28 (5.7%) of the 489 patients suffered bleeding that was severe enough to require discontinuation of the anticoagulant therapy. There were five deaths associated with bleeding, and in at least two of these cases bleeding was the main factor causing death. A significantly higher incidence of bleeding was observed in the group receiving heparin intramuscularly than in the groups given phenindione or bishydroxycoumarin. The group receiving cyclocumarel compared unfavorably with that receiving phenindione. Vitamin K_1 and K_3 oxide were effective in correcting hypoprothrombinemia caused by anticoagulants given orally. Daily prothrombin determinations allowed oral administration of anticoagulants to be controlled with slight risk of bleeding. Clotting time determinations were less successful in the control of heparin given intramuscularly. It is possible that, with heparin given intravenously, the control is more precise and the danger of bleeding less.

Isoniazid in Childhood Tuberculosis.—Isoniazid was used for the treatment of 50 children with tuberculosis, including some with tuberculous meningitis, tracheobronchial ulcerations, miliary tuberculosis, extensive lesions of the lung parenchyma, massive mediastinal lymph nodes, pleural effusion, tuberculous pericarditis, tuberculous mastoids, and persistent bacillary positive sinus from a hip. The dose of the drug used up to the end of May, 1952, was 3 mg. per kilogram of body weight. This was increased to 10 mg. per kilogram of body weight after the May, 1952, meeting of the American Trudeau Society. This dose was maintained for from two to four months without toxic symptoms in most of the patients. It was usually reduced to 5 mg. per kilogram of body weight at the end of this time, or sooner, if anorexia developed. Results showed that most human tubercle bacilli are sensitive to isoniazid and do not lose this sensitivity for months. Oral administration produced good plasma levels and, in the presence of meningitis, good spinal fluid levels. There seems, therefore, no indication for parenteral treatment. The drug produced rapid initial beneficial effects, such as weight gains, drop in erythrocyte sedimentation rate, and defervescence in most patients; these were not always maintained and other drugs had to be added later. Cortisone-like effects, or adrenogenic ones, were noted fairly often; they were pronounced in a few cases. The drug may cause increased ketosteroid excretion over a period of months. Isoniazid should not be used without streptomycin in patients with tuberculous meningitis; in early cases of the disease isoniazid may eliminate the necessity for intrathecal therapy when combined with streptomycin given by the intramuscular route alone. Isoniazid should not be used in far advanced cases of meningitis because of its additional disturbing effect on the electrolyte balance and its tendency to produce convulsions. To date, tracheobronchial ulcerations showed the most striking improvements of any type of tuberculosis in children. The characteristic "wheeze" disappeared rapidly, and the ulcers healed within three to six months.

Tuberculosis of Superficial Lymph Nodes.—Of 9,218 patients treated at the Toronto Hospital for Tuberculosis in Weston, Ontario, between 1932 and 1952, 210 (2.3%) had tuberculosis of the superficial lymph nodes. The highest age incidence was in the age group between 15 and 29 years, and there were only 30 patients less than 15 years of age. As infection with the bovine bacillus through milk has now been virtually eliminated from the province of Ontario, tuberculosis of the lymph nodes is no longer predominantly a disease of childhood, but its maximum incidence follows the incidence of tuberculosis in general. Associated tuberculosis in other parts of the body occurred in 185 (88%) of the 210 patients, most commonly in the lungs (161 patients) and bones and joints (46 patients), and this greatly affected the end-results of treatment. Of the 210 patients, 25 were North American Indians and Eskimos who showed the usual low resistance to the disease. Cervical lymph nodes were involved in 194 patients (92%), and 39 of these had generalized involvement of the lymph nodes in the neck, a condition resulting from unhindered lymphatic spread from node to node rather than from blood stream dissemination. Twenty-one of the 39 patients died, indicating an unfavorable prognosis in generalized involvement of the lymph nodes, though the disease in the lymph nodes itself is very rarely the cause of death. Diagnosis by microscopic examination of the tissues may be very difficult and bacteriological proof is the only certain proof. Best results were obtained by long-term intermittent treatment with streptomycin (1 gm. twice a week) combined with daily administration of 10 gm. of *p*-aminosalicylic acid. Any residual mass or sinus may be excised by local resection when the disease has become stationary or quiescent. Isoniazid was not used long enough for evaluation of its effect. Forty-eight patients (23%) died of some form of tuberculosis while in the sanatorium; most of these died before streptomycin became available. At present the mortality is much lower. There will be recurrences after adequate treatment in only 1 to 2% of the patients.

Deutsche medizinische Wochenschrift, Stuttgart

78:1315-1354 (Sept. 25) 1953. **Partial Index**

Problems of Chronic Hepatitis. K. Beckmann.—p. 1315.
Late and Permanent Somatic Damage Secondary to Dystrophy. H. W. Bansi.—p. 1318.
*Does Progression into Genuine Diabetes Mellitus Occur from Renal Glycosuria? Follow-Up Examinations in 60 Patients with Renal Glycosuria. H. Robbers and K. Rümelin.—p. 1321.
Gastric Mucus and Gastric Ferments. A. Mahlo.—p. 1323.

Renal Glycosuria and Diabetes Mellitus.—Sixty patients with renal glycosuria were followed up for 2 to 36 years. The duration of the disease exceeded eight years in 47 of the 60 patients. Six of the patients died, but symptoms of genuine diabetes mellitus were not manifested up to the time of death. The causes of death were bone sarcoma, perforating ulcer, coronary thrombosis, apoplectic stroke, ileus, and decrepitude. Follow-up revealed that the glycosuria continued constantly for many years. In rare cases it disappeared completely. Blood sugar curves were normal and did never show an elevated level after a second dose of dextrose given by mouth one hour after a first dose. Subjective complaints such as thirst, fatigue, and pruritus were mainly functional and became less with advanced age. Progression into genuine diabetes mellitus was not observed in any of the 54 patients who survived. The simultaneous occurrence in one person of a gene for renal glycosuria and one for diabetes mellitus is possible but rare. Genuine pancreatic diabetes may be manifested in the course of renal diabetes; these occurrences are independent of one another; therefore, one cannot speak of a progression of renal glycosuria into diabetes mellitus. Renal glycosuria is caused by a hereditary disturbance of the central organ that regulates the internal secretion, resulting in a secondary failure of the cells lining the proximal convoluted tubules of the kidneys to reabsorb the glucose.

Die Medizinische, Stuttgart

No. 37:1177-1212 (Sept. 12) 1953. **Partial Index**

Acute and Chronic Pyuria in Childhood. H. Kleinschmidt.—p. 1177.
Poliomyelitis—A Disease of Filth or of Civilization. E. Maier.—p. 1180.
Aspects of Spasmophilia: General Convulsions as Manifestation of Spasmophilia. J. Stoermer.—p. 1182.
Problem of Asthma: Observations on Children and Adults. J. Biermann.—p. 1185.
Treatment of Influenza Meningitis. E. Hömmken.—p. 1190.
A Really New Micromethod of Blood Sedimentation. F. Frimberger.—p. 1193.
*Experiences with Use of T Vitamin (Goetsch) in Raising Weak Newborn and Premature Infants. H. Schmidt.—p. 1202.

Vitamin T (Goetsch) in the Care of Newborn and Premature Infants.—Schmidt presents observations on the use of vitamin T (Goetsch) in 28 premature infants and in 52 full-term infants with retarded development. The commercially available vitamin T preparation employed in this study had been demonstrated to contain vitamin B_{12}, folic acid, citrovorum factor (folinic acid), and Lactobacillus bulgaricus factor. In contradistinction to other investigators Schmidt did not commence with very small doses, but administered 5 drops twice daily of the vitamin T preparation even to weak premature infants. Older infants were given 10 drops twice daily and later sometimes 10 drops 3 times daily. The drops were usually given in milk. In one premature infant (weight 1,300 gm.), treatment was continued for eight weeks, but most of the other

children received the vitamin T for only from 9 to 21 days. The results obtained were favorable, in that newborn with fluctuating or flat weight curves showed a tendency to increase in weight. The vitamin preparation was well tolerated, the stools remained normal, and no intestinal disturbances resulted, even in the weakest premature infants. The weight increase obtained under the influence of vitamin T medication in premature and poorly developing full-term infants compared favorably with that of a control group of normal infants.

Gazeta Médica Portuguesa, Lisbon

6:429-584 (No. 3) 1953. **Partial Index**

*New Method for Establishing Indications of Hypophysial Roentgen Therapy in Diabetes. (Preliminary Note). E. Pais.—p. 429.
Lymphosarcoma of Mediastinum of Acute Evolution: Diagnosis from Neoplastic Cells in Pericardial Liquid. M. de Alemquer.—p. 432.
Rational Surgical Treatment of Gastric Cancer: Total Gastrectomy. M. Conde.—p. 450.
In Vitro Effects of Vitamin B_{12}, Folic Acid, and Uracil on Bone Marrow in Megaloblastic Anemia: Two Cases. F. Parreira.—p. 527.

New Indications for Hypophysial Roentgen Therapy of Diabetes.—The author observed in previous work that *p*-oxypropiophenone, given to 29 patients with diabetes mellitus, produced hypoglycemia in almost all of them. Hypoglycemia was marked in patients with insulin resistance and in obese hypertensive patients with insulin sensitivity. The effects of the drug were transient. The author believes that hypoglycemia following administration of *p*-oxypropiophenone is due to inhibition of the secretion of glycemia-stimulating hormones, which are overproduced when the hypophysial factor is predominant in diabetes. The method for determining indications for roentgen therapy includes the following steps. Blood is taken from a fasting patient, and the level of glycemia is determined. Immediately after taking the blood, a dose of 1.5 gm. (six tablets of 0.25 gm. each) of *p*-oxypropiophenone is given to the patient by mouth. Half an hour later and for three consecutive hours, blood is drawn at intervals of 30 minutes and the curve of glycemia recorded. If at any time in the course of this procedure, glycemia falls 15% or more in relation to the level of fasting glycemia, a predominant hypophysial disorder in the origin of diabetes and the probabilities of good results from hypophysial roentgen therapy in the given case are indicated. Good results of hypophysial roentgen therapy last longer and are more constant than those of *p*-oxypropiophenone.

Irish Journal of Medical Science, Dublin

No. 333:337-372 (Sept.) 1953. **Partial Index**

Experience in Prevention of Air-Borne Disease. C. Dickson.—p. 337.
Immunity and Hypersensitivity in Tuberculosis. P. D. J. Holland.—p. 345.
Prospect of Childhood Tuberculosis in Dublin. M. Dunlevy.—p. 353.

Journal of Hygiene, London

51:293-425 (Sept.) 1953. **Partial Index**

Interaction of Tetanus Toxin and Antitoxin. B. Cinader and B. Weitz. —p. 293.
Variation in Complement-Fixing Activity of Rickettsia Burneti During Egg Adaptation. M. G. P. Stoker.—p. 311.
Some Effects of Chloramphenicol in the Gut. J. D. Gray.—p. 322.
*Epidemiology of Canicola Fever. W. I. M. McIntyre and H. E. Seiler. —p. 330.
Effect of Tuberculin on Sensitized and Normal Leucocytes. J. Marks and D. M. James.—p. 340.
Bacteriology of Dehydrated Fish: II. Effect of Storage Conditions on Bacterial Flora. J. M. Shewan.—p. 347.
Studies on Respiratory Infection: I. Influence of Particle Size on Respiratory Infection with Anthrax Spores. H. A. Druett, D. W. Henderson, L. Packman and S. Peacock.—p. 359.
Respiratory Retention of Bacterial Aerosols: Experiments with Radioactive Spores. G. J. Harper and J. D. Morton.—p. 372.
Thermal Comfort in Warm and Humid Atmospheres; Observations on Groups and Individuals in Singapore. F. P. Ellis.—p. 386.

Epidemiology of Canicola Fever.—Surveys have shown that from 25 to 40% of dogs reveal evidence of past infection with Leptospira canicola, and, as the carrier state in dogs may last as long as 4½ years, the potential sources of infection must be considerable in most areas. Several explanations have been advanced for the small number of reported human cases in relation to the high rate of dog infection. It has been argued that L. canicola has a low virulence for man and that for human infection to occur very close contact with the dejecta of infective dogs is necessary. It has also been suggested that the incidence in man is higher than is realized and that many cases of human disease are unrecognized. During 1951 all cases of canine leptospirosis, which had been fully investigated at the Veterinary College in Edinburgh, were used as the basis for an inquiry. The owners of dogs that had been recently ill or that were attending for follow-up after earlier infection were asked to give the name of their family physician. After consultation with the practitioners concerned, the families were visited. An inquiry into the home circumstances surrounding the illness of the dog was made, particularly in relation to soiling of the floor by urine and other dejecta. The history of illness among human household contacts was also obtained and the contacts were asked to agree to serologic examination and to submit a sample of urine for analysis. Altogether 137 household contacts were examined and blood samples from 99, or 72.3%, were tested for agglutination against L. canicola. All serums were normal. The results of the present survey and the experience with some reported cases of human canicola fever show that there is great variation in the risk of infection to owners and others living in the same house with diseased dogs. Some other source of infection common to man and dog seems possible. Dog owners should be made aware of the possibilities of infection and of the importance of observing hygienic principles when handling dogs and particularly when dealing with dejecta.

Journal of Laryngology and Otology, London

67:581-640 (Oct.) 1953

Deep Infections of Neck with Special Study of 32 Cases. D. L. Chadwick and C. E. Gabriel.—p. 581.
"Mixed Salivary" Tumours of Upper Respiratory Tract. V. Lambert. —p. 603.
Papillary Cystadenoma of Larynx. D. Ranger and A. C. Thackray. —p. 609.
Dysphagia Due to Cervical Spondylosis. F. Bauer.—p. 615.

Journal of Physiology, Cambridge

121:433-640 (Sept.) 1953. **Partial Index**

Gastric Secretion Induced by Histamine and Its Relationship to Rate of Blood Flow. J. E. Thompson and J. R. Vane.—p. 433.
Rate of Sodium Extrusion from Human Erythrocytes. E. J. Harris and T. A. J. Prankerd.—p. 470.
Defects of Colour-Sense Mechanism as Indicated by Accommodation Reflex. E. F. Fincham.—p. 570.
Cardiovascular Responses to Bladder Distension in Paraplegic Patients. D. J. C. Cunningham, L. Guttmann, D. Whitteridge and C. H. Wyndham.—p. 581.
Cholinesterase Activity of Arteries. R. H. S. Thompson and A. Tickner. —p. 623.
Cation Exchanges in Sympathetic Ganglia. E. J. Harris and H. McLennan. —p. 629.

Lancet, London

2:579-628 (Sept. 19) 1953

Renal Factors in Production of Hypertension. C. Wilson.—p. 579.
*Carcinoma of Gall-Bladder: Statistical Study. L. Cooke, F. A. Jones and M. K. Keech.—p. 585.
Acid-Base Disturbance and Potassium Depletion in Some Surgical Patients. J. E. Richardson, J. R. Billinghurst and D. W. Vere.—p. 587.
Acroparaesthesiae in Carpal-Tunnel Syndrome. M. Kremer, R. W. Gilliatt, J. S. R. Golding and T. G. Wilson.—p. 590.
Pneumatic-Tourniquet Test in Carpal-Tunnel Syndrome. R. W. Gilliatt and T. G. Wilson.—p. 595.
Intestinal Cul-De-Sac Phenomena in Man. J. Naish and W. M. Capper. —p. 597.

Carcinoma of Gallbladder.—The authors assess the incidence of carcinoma of the gallbladder and evaluate its relationship to gallstones. Cooke and co-workers obtained the registrar-general's figures on carcinoma of gallbladder and bile ducts in England and Wales, and for comparison they examined the necropsy records at the Postgraduate Medical School, Hammersmith, over the 10 years 1941-1950 and at the Central Middlesex Hospital over the 5 years 1947-1951. It was interesting that the proportion of all cancers of the liver and biliary passages, expressed as a percentage of all cases of cancer,

was almost identical in the hospital figures and in the registrar-general's return, but there was a reversal of the ratio of carcinoma of the gallbladder to carcinoma of the bile duct. In the hospital necropsy series, bile duct carcinoma is twice as common as carcinoma of the gallbladder, whereas in the registrar-general's figures carcinoma of the bile duct is only a quarter as common as carcinoma of the gallbladder. There can be no doubt that the hospital series is the more accurate of the two. Carcinoma of the bile duct is easily confused with carcinoma of the liver, and it is likely that in the registrar-general's figures some of the bile duct cases were included under the heading of primary carcinoma of the liver. It seems clear that in Britain cancer of the gallbladder accounts for less than 1% of all deaths from cancer. Reports are cited from various countries that show that a high percentage of patients with carcinoma of the gallbladder also have gallstones, the percentages ranging from 57 to 88%. In order to assess the risk of carcinoma of the gallbladder developing in a person with a gallstone, scrutiny was made of all the necropsy records at a hospital having very detailed and accurate records. Carcinoma of the gallbladder was found at necropsy in 3% of 231 patients in whom gallstones were present. Carcinoma, however, is not the only risk associated with gallstones. In analyzing the necropsy records the opportunity was taken to record whether or not the presence of gallstones had contributed to the death of the patient—for example, by producing obstructive jaundice or empyema of the gallbladder. Studied in this way, the gallstones had exerted an appreciable effect. In 30 of the 231 patients with gallstones, 1 in 8, death was the direct consequence of the stones. Evidence is cited that indicates that it seems reasonable to reserve surgery for patients who have troublesome symptoms from their gallstones. The risk of carcinoma is not in itself sufficient reason for advocating cholecystectomy for symptomless gallstones.

153
53

2:629-684 (Sept. 26) 1953

Methodolgy of Clinical Science. J. Spence.—p. 629.
*Renal Factors in Production of Hypertension. C. Wilson.—p. 632.
Clinical Pattern of Chronic Bronchitis. N. C. Oswald, J. T. Harold and W. J. Martin.—p. 639.
*Orbital Leucotomy (Isolation of Orbital Cortex by Open Operation). P. M. Tow and W. Lewin.—p. 644.
Pyrexia in the Puerperium. R. M. Calman and J. Gibson.—p. 649.
Cervical Spondylosis Simulating Motor-Neurone Disease. L. A. Liversedge, E. C. Hutchinson and J. B. Lyons.—p. 652.
Malaria Control in Borneo. J. McArthur.—p. 654.
Foreign Body in Ileum. C. M. Ottley.—p. 656.

Renal Factors in Hypertension.—Wilson feels that it is tempting to speculate that the kidneys and adrenals form part of a homeostatic mechanism which, through the control of tissue electrolytes, maintains arteriolar tone and adapts the blood pressure to changes in the internal environment. He discusses the role of the adrenals, assuming that some active principle resembling the salt hormone is involved. It is possible that other adrenal steroids may also play a part. Cortisone is known to produce hypertension under certain conditions. If experiments have established a reasonable presumption that renal hypertension is maintained through some action of the kidney on an adrenal cortical hormone and that this in turn acts through the influence of tissue electrolyte distribution on arteriolar tone, then the first step has been taken toward an understanding of the physiological mechanisms involved in renal hypertension. Discussing kidney lesions and hypertension, Wilson shows that the concept of the vicious circle was a natural corollary of the dual proposition that, on the one hand, renal vascular occlusion gives rise to hypertension and that, on the other, hypertension leads to occlusive vascular lesions. With regard to the application of experimental results the author deals with certain problems of high blood pressure in primary disease of the kidneys, in particular chronic nephritis and unilateral renal disease.

Orbital Leukotomy.—Tow and Lewin practiced orbital leukotomy because of the evidence that the orbital surface, rather than the superolateral surface of the lobe, is concerned with the predominantly emotional and affective aspects of behavior, and that general personality damage is roughly proportional to the amount of frontal tissue destroyed. They regarded the operation as a first step in narrowing the full leukotomy procedure. In their choice of the orbital surface, they were influenced by the work of Scoville (1948 and 1949), who introduced a technique for "undercutting" all three surfaces of the frontal lobe. The operation of orbital leukotomy consists in making a line of cleavage with a brain spatula and a fine suction-tube at the junction of the grey and white matter above the orbital grey matter on each side, extending from the frontal tips back to the level of the base of the anterior clinoid processes, with interruption of the long and short association fibers to the thalamus and to the adjacent frontal cortex. In some cases it was found necessary to sacrifice a main venous tributary running across the face of the frontal pole, but apart from this, no major vessels are divided. By operating under direct vision and with reference to definite landmarks one attempts to produce a discrete isolation of the orbital cortex without damaging the adjacent frontal cortex or its blood supply. The authors had performed between January, 1950, and December, 1951, orbital leukotomy on 20 patients without a surgical death. The only fatality in this series took place 17 months after the operation. The patients were observed throughout their entire postoperative period to date, which now extends from one and a half to three years. Seven of the patients recovered and eight others improved. Recovery or improvement takes place in the first few weeks or months. Because physical and psychological complications are minimal and beneficial effects are comparable with those of prefrontal leukotomy, orbital leukotomy is recommended for trial, particularly in patients with severe intractable tension and disturbed behavior, as an alternative to the standard operation.

Medical Journal of Australia, Sydney

2:197-244 (Aug. 8) 1953

Physiological Principles in Management of Fluid and Electrolyte Problems in Infancy and Childhood. W. B. Macdonald.—p. 197.
Fluid and Electrolyte Problems in Newborn. K. Campbell.—p. 201.
Pathological Physiology, Assessment and Management of "Dehydration" in Entero-Colitis. H. Williams.—p. 203.
Fluid and Electrolyte Problems in Infants and Children: Intestinal Obstruction. E. S. Stuckey.—p. 205.
Minor Epilepsies. D. B. Hamilton.—p. 207.
Vitamin D Resistant Rickets. D. Galbraith.—p. 208.
Congenital or Neo-Natal Thrombocytopenic Purpura. S. E. L. Stening.—p. 210.
Recent Trends in Diagnosis and Treatment of Coeliac Disease. C. M. Anderson.—p. 211.
Urinary Excretion of Mercury in Pink Disease: Preliminary Report. F. W. Clements.—p. 213.
Poliomyelitis Virus in Tissue Culture. J. R. Thayer.—p. 215.
Coxsackie Virus Infections in Australia, with Special Reference to Their Epidemiology. N. F. Stanley.—p. 216.

2:245-280 (Aug. 15) 1953. **Partial Index**

Sociological Problem of Hemiplegia. W. S. Davidson.—p. 248.
Problem of Endemic Goitre. F. W. Clements.—p. 251.
Diagnosis by Sense of Smell. C. Engel.—p. 254.
Incidence of Tuberculosis in Queensland in Relation to Climate and Occupation. B. Smith.—p. 258.

2:281-320 (Aug. 22) 1953

*Studies on Long Range Association Between Bulbar Poliomyelitis and Previous Tonsillectomy. R. V. Southcott.—p. 281.
Bloodless Operation for Paronychia. V. J. Kinsella.—p. 298.
Note on Possibility of Obtaining False Blood Group Results for Babies by Testing Cord Blood. B. Liddelow.—p. 299.

Association Between Bulbar Poliomyelitis and Previous Tonsillectomy.—A survey of patients who contracted poliomyelitis during the 1947-1948 epidemic in South Australia showed that, of the 103 patients in whom the disease was associated with paralysis, 40 had bulbar paralysis. Thirty-five of the 40 had previously undergone tonsillectomy; 4 had not. For one patient this information was not obtained. Only 1 of the 35 patients had had a tonsillectomy recently; there was a 15 day interval between tonsillectomy and onset of poliomyelitis, while 16 of the remaining 34 patients had contracted the disease five or more years after the tonsillectomy. No evidence was found of an association between previous tonsillectomy and poliomyelitis other than bulbar; both nonbulbar paralytic

and nonparalytic figures were tested. Comparison of age distribution of patients with bulbar and nonbulbar paralytic poliomyelitis showed that none of the 35 patients with bulbar poliomyelitis was younger than 5 years. The curve for the age distribution of the patients with bulbar poliomyelitis was much sharper than that of the patients with nonbulbar poliomyelitis associated with paralysis. Studies on the duration of the association between bulbar poliomyelitis and previous tonsillectomy revealed only short intervals since tonsillectomy in the younger age groups. The effect of the tonsillectomy, that is the strength of the association between bulbar poliomyelitis and previous tonsillectomy, was still significant in the group between 17 and 20 years, suggesting that the duration of the effect is likely to be prolonged since the modal age for tonsillectomy is five or six years. The figures were too small for definite conclusions in the group of patients with bulbar paralysis aged 21 and over. The effect of tonsillectomy lasted at least 9 or 10 years in the group between 12 and 20 years. Longer durations for the association between bulbar poliomyelitis and tonsillectomy, even possibly lifelong, are not excluded and are possible. The age distribution of the patients with bulbar paralysis but who did not have a tonsillectomy suggested that there is an increased liability to contraction of bulbar poliomyelitis with certain increases of age, independent of tonsillectomy. The association between bulbar poliomyelitis and previous tonsillectomy favors the concept that the poliomyelitis virus gains entry to the medulla via the motor pathway from the tonsillar area of the pharynx to the nucleus ambiguus. There is no evidence that the tonsils are specifically protective against this port of entry of the virus, but that the trauma of tonsillectomy renders the motor nerves of the tonsillar region more accessible to the entry of the virus to them from the pharyngeal surface. A brief survey of the patients who contracted poliomyelitis during the 1949-1950 epidemic of poliomyelitis in South Australia showed that of 19 patients with bulbar paralysis 14 had previously been tonsillectomized and 5 had not. In only 1 of the 14 patients was the tonsillectomy recent, with an 11 days interval between tonsillectomy and onset of symptoms.

Medicina, Buenos Aires

13:199-256 (Aug.) 1953. Partial Index

Venous Pressure in Fold of Elbow: Clinical and Experimental Study. J. L. Duomarco and R. Rimini.—p. 199.
*Malignant Tumors of Hypophysis. A. Mosovich.—p. 218.
Ballistocardiographic Changes in Sarcoidosis. L. de Soldati, J. Doyle and R. Navarro Viola.—p. 228.

Malignant Tumors of Hypophysis.—There is a small group of hypophysial tumors that, unlike the benign hypophysial adenoma, invade the cranial bones, paranasal sinuses, dura mater, leptomeninges, cerebral nerves, brain stem, and cerebral tissue. The neurological symptoms correspond to the structures in which the tumor grows. They consist mainly of repeated crises of acute headache with nausea and vomiting, ocular and visual disturbances, disorders of hearing, paralysis of the cerebral nerves, trigeminal neuralgia, and, in women, amenorrhea of long duration. The diagnosis is made by roentgenography and tomography. These are likely to show an enormous enlargement and erosion of the sella turcica and the presence of a tumor in the clinoid process, the temporal and occipital bones, the paranasal sinuses, or other structures. The tumor grows slowly and does not metastasize. Roentgen therapy produces temporary improvement. Violent aggravation of the symptoms with multiple paralyses of the cerebral nerves, ocular proptosis, pain of the eyeballs, and photophobia mark the onset of the final stage that lasts a few hours. There is mental disorientation of the patient, acute general convulsions, and finally coma. The author reports two cases. The first patient, a 32-year-old man, had acromegaly for 17 years. Roentgen therapy controlled almost all of the symptoms for four years, during which the patient was able to work. The second patient, a 35-year-old woman, had neurological symptoms for four years prior to the treatment and amenorrhea for the last two years. Roentgen therapy improved moderately the symptoms for six months. The second roentgen treatment failed. In both cases the final stage lasted only two days. It was observed at necropsy that the involvement of the leptomeninges progressed to the pontocerebellar angle, the protuberance, and the sinus cavernosus in one case and to the optic nerves, left gasserian ganglion, and paranasal sinuses in the other. In both cases the tumor infiltrated the sphenoid and right petrous bones. The blood vessels and nerves near the tumor were buried in the neoplastic tissue, but their structure was well preserved. The author describes the histological differences between these tumors and benign hypophysial adenomas. The term malignant adenoma is more proper than hypophysial carcinoma, by which the aforementioned tumors are commonly designated.

Minerva Medica, Turin

44:33-76 (July 7) 1953

Obesity. G. Izar.—p. 33.
Leukemia Associated with Tuberculosis. M. Consolini.—p. 55.
*Treatment of Hyperthyroidism with I^{131}. A. Costa, G. M. Ferraris, E. Marchis and F. Marocco.—p. 58.
Lymphocytogenesis and Assumptions for a Comparison Between Lymphatic and Myeloid Tissues. G. Fiorio.—p. 63.

Radioactive Iodine in Hyperthyroidism.—The authors used I^{131} to treat 18 patients with Basedow's disease and 7 with Plummer's disease. They conclude that this treatment should be limited to aged persons with hyperthyroidism, to those with recurrences after surgery or who failed to respond to antithyroid drugs, those in whom hyperthyroidism is associated with heart disease, and those who refuse surgery. One of the main problems of this treatment is the determination of a suitable dose of I^{131}. Although many methods have been used to estimate the effective dose, the best is still to calculate it according to the volume of the gland and the uptake rate of I^{131}. The initial dose should range from 5 to 10 mc. to avoid severe local reactions (painful congestion of the thyroid and dysphagia), thyrotoxic crises, and excessive thyroid inhibition resulting in hypothyroidism. Generally the good effects of radioactive iodine therapy become manifest after one or two months. If the first dose proved inadequate it is then safe to administer additional I^{131} up to a total dose of from 20 to 25 mc. An initial dose of 15 to 25 mc. generally causes side-effects as it did in some of the authors' patients. They aggravate the thyrotoxic state and a thyrotoxic crisis follows. The authors suggest treating the patients before and after the administration of I^{131} with antithyroid drugs. A tracer dose of I^{131} should also be given before the treatment is instituted.

44:77-154 (July 11) 1953

Extraperiosteal Polystan According to J. L. Hansen in Treatment of Cavitary Pulmonary Tuberculosis. G. Censi and P. Maraschio.—p. 77.
*Studies on Q Fever in Emilia and Romagna Regions: Epidemic Center of a Familial Character in the Bologna Province. C. Badioli and V. Nevola.—p. 89.
Uroenteron in Treatment of Gastric and Duodenal Ulcer. D. A. Scala and A. Grasso.—p. 93.
Use of Nicotine K-Strophanthin in Congestive Heart Failure. A. Martelli.—p. 100.
Infantile Tuberculosis in Aosta Valley: Diffusion, Evolution, and Death Rate. G. Maschio and S. Mancini.—p. 104.

Epidemic of Q Fever.—Numerous cases of febrile influenza with or without mild complications of the respiratory apparatus were observed at Ozzano in the province of Bologna during the first six months of 1952. The clinical manifestations were atypical in six of these persons, and pulmonary types due to virus and rickettsiae were suspected. Two of these six patients were members of a family of share croppers four of whom had also been ill within a short time of each other. Laboratory studies to establish a definite a posteriori diagnosis were made on the serum of these patients in July. Since the reaction to the complement fixation test was positive for Q fever in all the patients, the serum of the other members of the family and of other persons who had been ill during the epidemic was also studied. The reaction was positive in 8 of the 14 members of the family and one housewife among the other persons. Attempts were not made to isolate the Rickettsia burneti because of the long interval that had elapsed from the time of the illness. The disease had become manifest

with the classic picture of pneumonia in four of nine patients and with a picture of pseudoinfluenza in the other five. Penicillin and sulfonamides had no effect on the disease, and months later the agglutination titer was still elevated. The source of the infection was ascribed to a herd of sheep that ranged near the farmers' house many months of the year. The serum agglutination was positive for Q fever in 3 of the 15 sheep that were studied. The epidemic had begun at the time the births among the animals were more numerous and when the contact was more likely to occur. The members of the family had probably become infected through material contaminated with feces and urine spread in the vicinity of the house by the sheep. For the three persons who had no apparent contact with the animals the source of infection was attributed to fresh cheese they had consumed and that had been prepared from milk of these sheep.

44:521-548 (Sept. 5) 1953

Physiopathology of Nutrition: Theoretical and Practical Progress. G. Di Macco and F. Vaccarica.—p. 521.

*Hematic Syndromes During Course of Porphyria. R. Trainito and V. Prato.—p. 529.

Biochemistry of Myocardium and Its Relationships with Systemic Biochemistry. E. Albertini and R. Della Volpe.—p. 534.

Antibiotics and Parapneumothoracic Exudative Pleurisy. B. Tumminello and C. Rossini.—p. 539.

Blood Picture in Patients with Porphyria.—The authors reviewed the cases of porphyria reported in the literature and studied in particular 53 cases in which the blood findings had been discussed. The blood picture varied during the various phases of the disease. Polyglobulism was present (11 cases) in the initial phase and severe anemia (13 cases) during the final stage of the disease when the patient's condition was precarious. The findings of blood chemistry studies were normal during the intermediate phase of the disease when the patient's general condition was not severely impaired. The passage from a state of polyglobulism to one of anemia through an intermediate state with normal blood chemistry findings has been proved by various authors with repeated blood examinations. Polyglobulism, when present, was always normochromic. Because the blood chemistry in patients with porphyria has been studied only during the late phases of the disease, polyglobulism was believed to be more uncommon than it really is. The origin of polyglobulism is ascribed to a stimulating action of the porphyrins on erythropoiesis. This action has a tendency to become attenuated and disappear during the later phases of the disease, and this explains why polyglobulism is less common during those phases. Anemia, when present, was always oligochromic. Several theories have been advanced to explain its origin in patients with porphyria. The finding of large amounts of iron in the liver and spleen of patients in whom porphyria was complicated by a severe anemia seems to confirm Vannotti's theory that it is due to inability of the red blood cells to utilize iron. Studies of the bone marrow during the period of severe anemia revealed a normoblastic erythropoiesis with a large number of erythroblasts. The number of the white blood cells was not altered during the initial phase of the disease, but there was a neutrophilic leukocytosis in the acute phase, whereas the number decreased during the late stages when severe anemia was present. Some authors have reported an increase of the number of lymphocytes over that of neutrophil granulocytes. This proved to be true only in those cases in which the marrow was severely impaired.

Nederlandsch Tijdschrift v. Geneeskunde, Amsterdam

97:2117-2188 (Aug. 15) 1953. **Partial Index**

*Harmful Effects of Diets Deficient in Proteins. A. Arends and H. O. Nieweg.—p. 2123.

Risk of Stillbirth of Children Late in Order of Birth or Children of Mothers Advanced in Years. D. Hoogendoorn.—p. 2130.

Harmful Effects of Diets Deficient in Proteins.—Arends and Nieweg present the histories of five patients in whom various pathological conditions developed as the result of low protein diets. A woman, aged 52, had eaten a low protein diet for about 18 months because of disturbances in renal function, and for about six weeks her diet had been practically free of protein. After this megaloblastic anemia developed. Liver function tests revealed megaloblastic anemia in a 42-year-old woman whose diet over a period of six years had contained no animal proteins because she had renal disease with hypertension. An 18-year-old boy who had received a diet very low in protein because uremia was always impending, had a blood picture characteristic of erythroblastic anemia. He died and necropsy revealed severe atrophy of the spleen. The fourth patient, a 53-year-old woman, had been given a low protein diet for six months. This woman and the fifth patient, a man aged 45, showed severe liver damage at autopsy. Protein deficiency may have a harmful effect on the liver.

Nordisk Medicin, Stockholm

50:1217-1250 (Sept. 3) 1953. **Partial Index**

*Burns and Their Treatment. H. Schjelderup.—p. 1221.

Treatment of Burns in Peace and War Time. A. Bertelsen and R. Movin. —p. 1227.

Exposed Ointment Treatment of Burns. K. Skøtt Andresen and H. Tønnesen.—p. 1234.

Clinical Experiences with Intra-Arterial Blood Transfusion. H. Baden. —p. 1236.

Bullet Entrance Without Exit Wound. R. Movin.—p. 1240.

Burns and Their Treatment.—Schjelderup says that shock treatment of burns in adults should be started when the burned area exceeds 15% of the body surface. According to Wallace's rule of 9 for determining the amount of fluids to be given intravenously during the first 24 hours of treatment, the surface of the body is divided into areas of 9 and 18% of the whole; ½ liter colloids and ½ liter sodium chloride solution per 9% of burned surface are given intravenously, together with 2 liters of fluid orally. The estimated amount of fluid is administered in the course of the first 24 hours after the injury, half of it during the first 8 hours, reckoning the time from the moment of the injury, and the rest during the remaining 16 hours. A limit is set at 3 liters of colloids, 3 liters of electrolytes, and 2 liters of fluids orally. For the second day the quantity of fluids is cut in half. A table for computation of the amount of fluids for children is included. Hyperthermia in children is cautioned against. The Evans formula for assessment of the amount of fluids is also given. To control the effect of treatment the urinary output, hemoglobin percentage, and blood pressure must be watched carefully. All deep and extensive burns require whole blood transfusion from the start; half the estimated amount of colloids and electrolytes is replaced by whole blood. The synthetic colloids, such as dextran, Macrodex (6% solution of dextran in 0.9% isotonic sodium chloride solution), and polyvinylpyrolidone (Plasmosan), are recommended. Anemia develops during the granulation period; the only treatment is blood transfusion. The aim is to cover the open surfaces with skin grafts as soon as possible. The hemoglobin percentage must not be allowed to fall below 60, as skin grafts do not take when anemia becomes marked. Wallace's exposure treatment with early excision and grafting is recommended.

Philippine Medical Association Journal, Manila

29:321-388 (July) 1953

Effects of Atomic Explosion on Human Body. P. G. Potenciano.—p. 321.

Bacteriological Examination of Water Samples from Houses of Cases and Contacts of Typhoid Fever and Dysentery and from Public Eating Places. A. P. de Roda and R. Sta. Ana.—p. 346.

Practical Management of Diarrhea as Observed at Louisville Children's Hospital and Louisville General Hospital, Louisville, Ky. C. R. Belmonte.—p. 353.

Intestinal Obstruction. P. N. Mayuga and A. A. Lauengco.—p. 361.

29:391-450 (Aug.) 1953

Widening Indications for Cesarean Section. H. Baja-Panlilio and G. T. Aragon.—p. 391.

Central Control of Intraocular Pressure and Its Relationship to Concepts of Glaucoma. J. V. Tamesis.—p. 398.

Report on Anatomic Measurements of Normal Sella Turcica in Filipinos. F. Torres, G. Gabriel and G. Manigbas-Galang.—p. 405.

Report on Radiographic Measurements of Normal Sella Turcica in Filipinos. P. J. Garcia and A. M. Laxamana.—p. 413.

Practitioner, London

171:229-338 (Sept.) 1953. **Partial Index**

Bacterial Resistance to Antibiotics. F. R. Selbie.—p. 239.
Early Diagnosis of Cancer. J. Bamforth.—p. 244.
Management of Anticoagulant Therapy. A. Brown.—p. 254.
Liver Function Tests. W. Bowman.—p. 261.
Control Salt and Water Balance. W. H. H. Merivale.—p. 267.
Collection of Specimens for Laboratory. G. A. Dunlop.—p. 276.
Review of 87 Patients Receiving Treatment for Pernicious Anaemia. H. Brebner.—p. 280.
Calcium Chloride Aerosol in Treatment of Wheezing. T. H. Howell. —p. 287.

Presse Médicale, Paris

61:1165-1184 (Sept. 19) 1953

*Sleep-Therapy and Cure by Sleep as Psychiatric and Psychosomatic Therapeutics. J. Delay, P. Deniker and Y. Tardieu.—p. 1165.
Five Years' Experience with Male Genital Tuberculosis in Algeria. J. Ducassou.—p. 1166.
New Local Anesthetic with Prolonged Action: Efocaine. G. Seille and M. Klein.—p. 1168.

Sleep Therapy and Cure by Sleep as Psychiatric and Psychosomatic Therapeutics.—A distinction should be made between sleep therapy, which aims to set the autonomic nervous system at rest, and treatment involving the therapeutic aspects of sleep itself. In both methods a neuroplegic, chlorpromazine (10-[γ-dimethylaminopropyl]-2-chlorophenothiazine hydrochloride) is the drug of choice for bringing about prolonged sleep. Results of the use of sleep therapy have been very encouraging in cases of agitation; acute psychosis, mental confusion, and subacute delirium tremens; anxiety, depression, and melancholia; schizophrenic excitation; hallucinatory and delirious syndromes; phobic neurosis, neurasthenia, hysteria, hypochondriasis, and psychosomatic disorders; insomnia resisting other methods of treatment; and toxicomania. In all but the most acutely affected patients the state of sleep induced by chlorpromazine need not be complete, but only pharmacodynamic. The patient must be carefully watched at all times, especially during the beginning of the treatment when rather large doses of the drug are being given in order to begin the sympathicoplegia. Although treatment may have to be continued over a period of several weeks, chlorpromazine is valuable in that it abates tension within 48 hours. The authors feel that sympathicoplegic sleep therapy is more manageable and of greater scope than is cure by sleep.

61:1205-1222 (Sept. 26) 1953

Results of Thorn's Test with Corticotropin (ACTH) in Several Cases of Helminthiasis. H. Galliard, J. Lapierre, M. Larivière and R. Berdonneau.—p. 1205.
New Cardiotonic: "Thevetine" (Digitalis Preparation): Clinical Experiment with 111 Patients. J. Celice, F. Plas and F. Jeanson.—p. 1207.
*Hypophysectomy in Man. P. Détrie.—p. 1209.

Hypophysectomy in Man.—Hypophysectomy has been performed in human beings because of Cushing's syndrome that does not yield to irradiation of the pituitary region or that shows a radioresistant relapse, severe arterial hypertension, severe diabetes with retinopathy and chronic nephritis not improved by adequate doses of insulin, malignant tumors of the breast and prostate, chorioma, and malignant melanoma. The basis for this operation is the apparent correlation between certain tumors and the sex hormones. It has been demonstrated experimentally that hypophysial implants stimulate the evolution of experimental cancers, that hypophysectomy hinders their appearance, and that it stops the action of sex hormones on certain glands. Results of the operations performed so far have been most successful with Cushing's disease, the only condition in which incomplete removal of the gland is authorized, and with chorioma. The operations were followed by death in all the patients with arterial hypertension; that and endocrine disorders seem to constitute the major contraindications to hypophysectomy. Otherwise, it appears not to be a dangerous operation unless the patient is in very poor condition. The main problem from the therapeutic point of view is whether subtotal exeresis of the hypophysis is sufficient for the inhibition of cancerous growths, in view of the fact that it has regenerated in some cases, and whether total exeresis is harmful to the body as a whole, despite the powers of hormone therapy. From the surgical point of view the problem is how to achieve a total hypophysectomy, if it is necessary, without injuring any of the surrounding structures.

Quarterly Journal of Medicine, Oxford

22:261-404 (July) 1953

Cholecystography: Observations on Technique of Examination and Interpretation of its Results. I. R. S. Gordon.—p. 261.
Biochemical and Pathological Studies of Congenital Porphyria. J. E. Kench, F. A. Langley and J. F. Wilkinson.—p. 285.
Bronchiectasis and Bronchostenosis Following Primary Tuberculosis in Infancy and Childhood. H. Williams and C. Anderson.—p. 295.
Anaemia of Adult Scurvy. B. Bronte-Stewart.—p. 309.
*Studies in Gout with Particular Reference to Value of Sodium Salicylate in Treatment. F. G. W. Marson.—p. 309.
Prognosis in Acute Disseminated Encephalomyelitis: With Note on Neuromyelitis Optica. H. G. Millet and M. J. Evans.—p. 347.
Causes of Post-Prandial Attacks of Palpitation and Weakness After Gastric Operation. W. H. Smith, R. Fraser, K. Staynes and J. M. Willcox.—p. 381.

Studies in Gout.—The subjects of these studies were 115 gouty patients. All were given crystalline colchicine tablets to relieve symptoms of acute gout. Of 32 suffering from chronic gout, 29 were treated with sodium salicylate. In only one did the blood serum uric acid level initially fail to drop; the patient showed severe renal impairment. A second patient refused to continue treatment; but for the other 27, sodium salicylate administered continuously for periods of up to 34 months had good results. Continuous treatment was shown to be necessary by the failure of an experimental dosage of the drug—90 grains (5.82 gm.) a day for three consecutive days per week—to maintain continuously a lowered serum uric acid level. Sodium salicylate can be tolerated for prolonged periods in a dosage sufficient to maintain the serum uric acid level at a normal or nearly normal level. Tolerance to the drug usually develops within a few weeks. With reasonable control, there is little risk of hemorrhagic complications. Experiments with diets of varying purine content confirmed the belief that the serum uric acid cannot be effectively controlled by the limitation of purine intake, because the change that it does bring about is too slight. The control of serum uric acid achieved by sodium salicylate therapy produced marked alleviation of the symptoms of chronic gout in the patients treated; the destructive changes induced by urate deposition were arrested and partially repaired. Twenty patients obtained complete relief from pains in the joints.

Rev. Asociación Médica Argentina, Buenos Aires

67:187-238 (June 15-30) 1953. **Partial Index**

*Asynchronic Nonsystemic Multiple Malignant Neoplasms: Case. N. Arenas and H. G. Bottaro.—p. 187.
General Physiopathology of Coma (Physiopathology of Conscient Functions). D. Ziziemsky.—p. 190.
Treatment of Residual Cavitation of Thoracoplasty. H. D. Aguilar. —p. 202.
Vaginal Hysterectomy: Indications in Treatment of Genital Prolapse. O. Blanchard and J. M. Gentile.—p. 217.
Revitalization of Skin and of Organism by Implantation of Autoplastic Grafts of Modified Natural Skin: Contribution to Problem of Unproperly So-Called Rejuvenation. I. Zelcer.—p. 226.

Multiple Malignant Neoplasms.—Instances of tumor presenting all or the first two of Billroth's postulates should be reported. According to these postulates, the tumors should have different histological characteristics, should have their origin in different organs, should follow an independent course, and should give rise to metastases according to their proper type. The last postulate may be lacking because metastases are not always present. The authors' patient, a woman 50 years old, had an osteosarcoma removed from the upper third of the left radius at the age of 32, an adenocarcinoma removed from the left breast at the age of 44, and a myosarcoma removed from the left thigh at the age of 49. The patient's father died from gastric cancer. Two brothers died from sarcoma of the thigh and

adenoma of the breast, respectively. The remaining four brothers are normal. Multiple cancer, as the cause of death, is extremely rare. If it is identified early, prompt surgical treatment is efficacious.

Riforma Medica, Naples

67:961-988 (Aug. 29) 1953

*Therapy in Epidemic Cerebrospinal Meningitis. G. Izar.—p. 961.
Nicotinic Acid and Changes in Oxygen Saturation of Blood in Venous Stasis. G. Calì, G. Lomeo and L. Nastri.—p. 967.
The Problem of Extracorporeal Oxygenation. S. Armenio.—p. 972.

Penicillin Therapy of Epidemic Meningitis.—The author discusses serum therapy, sulfonamides, and antibiotics in the treatment of epidemic meningitis, and he asserts that the best therapy is parenteral administration of penicillin in adequate doses. Five of his patients recovered completely after administration of that antibiotic. Three of them were given 1,000,000 I. U. of the antibiotic at admission and 500,000 units every three hours thereafter. The temperature returned to normal after 10, 8, and 12 days respectively. Aspecific meningitis, which was ascribed to excess doses of penicillin, developed in two who recovered after administration of the antibiotic was discontinued. The other two patients were given 1,000,000 units of penicillin at admission and 1,500,000 units of penicillin for prolonged action after three hours. This dose was repeated every 24 hours thereafter. On the fourth day the temperature was normal in one patient who recovered completely. A swelling had appeared on the left knee of the other patient suggesting that the meningococci had become localized in the knee. About 50 cc. of fluid containing polynuclear leukocytes and meningococci were removed, and 1,000,000 units of penicillin were introduced. The patient made a full recovery. There were no sequelae in any of the patients.

Rivista di Ostet. e Ginecologia, Florence

8:441-520 (July) 1953. **Partial Index**

Tuberculosis of Female Genital Organs and Streptomycin. L. Kyriakis.—p. 441.
*Study of Postpartum Hemorrhages Due to Afibrinogenemia: Fibrinolytic and Anticoagulant Action of Amniotic Fluid in Cases of Fetal Maceration. G. Vecchietti.—p. 443.
In Situ Cancer of Neck of Uterus. W. Ingiulla and E. Ogier.—p. 453.

Postpartum Hemorrhages Caused by Decrease or Absence of Fibrinogen.—Postpartum hemorrhages resulting from hypofibrinogenemia or afibrinogenemia occur frequently in women with anti-Rh isoimmunization and dead fetuses in utero and, independently from a state of isoimmunization, in women whose fetuses have undergone maceration. Several hypotheses have been advanced to explain the pathogenesis of this condition. Toxic effects of placental and fetal substances may interfere with the liver production of fibrinogen; substances of placental and amniotic origin with a thromboplastinic activity may enter the maternal circulation and cause defibrination of the plasma; or fibrinolytic enzymes originating from the decidua and the placenta may enter the maternal blood stream. These hemorrhages may also be the expression of an exaggerated fibrinolytic defense process following the penetration of thromboplastin into the maternal circulation. Previous studies have indicated that the amniotic fluid has an anticoagulant and fibrinolytic activity. Some authors are of the opinion that the fluid may enter the maternal circulation and cause pronounced blood coagulation defects and not acute embolism. The author studied the amniotic fluid of a woman in the eighth month of pregnancy whose fetus had been dead in utero one month. He removed transabdominally 50 cc. of turbid, reddish amniotic fluid, and four hours later a macerated fetus weighing 690 gm. was delivered. He removed about 18 cc. of cerebrospinal fluid from the third ventricle of the fetus and then studied the effect of the two fluids on the process of blood coagulation. There was a fibrinolytic and a definite heparin-like anticoagulant activity in both. In comparative studies with heparin, the anticoagulant activity of the fluids proved to be equal to that of a fluid containing from 5,000 to 10,000 I. U. of heparin. The amniotic fluid had a greater fibrinolytic activity, the cerebrospinal fluid a greater anticoagulant activity. Thus amniotic fluid penetrating into the maternal circulation may also be responsible for the postpartum hemorrhages that occur in women with anti-Rh isoimmunization with dead fetuses in utero and in those whose fetuses have undergone maceration.

Scandinavian J. of Clin. & Lab. Investigation, Oslo

5:207-298 (No. 3) 1953. **Partial Index**

Effect of Aneurin on Uterine Contractions. S. Timonen and K. A. Schroderus.—p. 207.
Occurrence of Chylomicrons in Blood in Young and Old Persons. A. Grüner and T. Hilden.—p. 236.
Effect of Heparin and Protamine Sulphate on Occurrence of Chylomicrons in Human Blood. A. Grüner, K. Hilden and T. Hilden.—p. 241.
Improved Instrument for Internal Standard Flame Photometry. V. Leppänen and N. Haliman.—p. 250.
Electrometric Method for Determination of Cholinesterase Activity. L. E. Tammelin.—p. 267.
Enzymatic Determination of Uric Acid with Detailed Directions. E. Praetorius and H. Poulsen.—p. 273.
Partition Chromatography of Porphyrins: New Apparatus. G. Y. Kennedy.—p. 281.
*Estimation of Portal Venous Pressure by Occlusive Hepatic Vein Catheterization. H. Krook.—p. 285.

Estimation of Portal Venous Pressure by Occlusive Catheterization of a Hepatic Vein.—A new method recently described by Myers and Taylor for measuring portal venous pressure by occlusive catheterization of a hepatic vein was tried on 10 persons without any symptoms or signs of hepatic disease, on 14 patients with chronic disease of the liver 10 of whom had liver cirrhosis and portal hypertension syndrome, and on 5 patients with congestive heart failure. The pressure recorded from the occluded hepatic vein in those without apparent liver disease ranged from 3 mm. Hg to 10 mm. Hg (average 6.4 mm. Hg). The pressure recorded from the occluded hepatic vein was increased in patients with cirrhosis, the increase usually varying with the severity of the clinical symptoms of hypertension. The pressure recorded in the 10 patients with portal hypertension syndrome varied from 12 mm. Hg to 27 mm. Hg (average 21 mm. Hg). The level of the pressure recorded in the five patients with congestive heart failure, three of whom had constrictive pericarditis, was about the same as that of the systemic vein pressure, i. e., 11 mm. Hg to 20 mm. Hg (average 15 mm. Hg). The pressure recorded from a central, unoccluded hepatic vein was low in both apparently healthy persons and patients with cirrhosis, the averages being 4 mm. Hg and 4.8 mm. Hg, respectively. There is much to suggest that the pressure measured with the aid of a catheter occluding a small peripheral branch of the hepatic vein represents the pressure in the portal vein and that the method is useful for assessing the degree of portal hypertension.

Schweizerische medizinische Wochenschrift, Basel

83:859-882 (Sept. 12) 1953. **Partial Index**

*Morphology and Pathogenesis of Subtotal and Total Coronary Occlusion (Intramural Hematoma, Thrombosis, Arteriosclerosis, and Coronaritis). N. Papacharalampous and H. U. Zollinger.—p. 859.
Appositional, Proximal Growth of Coronary Thrombi. H. U. Zollinger and N. Papacharalampous.—p. 864.
Mechanism of Tumor Formation. A. Graffi.—p. 865.

Morphology and Pathogenesis of Coronary Occlusion.—Macroscopic and microscopic studies made of the coronary arteries of 126 patients who died of coronary occlusion revealed that the occlusion was caused by intramural hematoma associated with coronary sclerosis in 14 (8 men and 6 women between the ages of 47 and 76 years), 11.1%; by intramural hematoma with secondary thrombosis associated with coronary sclerosis in 21 (14 male and 7 female patients between the ages of 12 and 84 years), 16.7%; by simple coronary sclerosis in 30 (21 men and 9 women between the ages of 40 and 79 years), 24%; by coronary thrombosis associated with simple coronary sclerosis in 50 (44 men and 6 women between the ages of 38 and 89 years), 39.5%; and by coronaritis in 11 (8 men and 3 women between the ages of 40 and 73 years), 8.7%. The great significance of coronary arteriosclerosis in coronary

occlusion was thus demonstrated. Generalized arteriosclerosis, which was observed in some of the patients of each of the five groups, also played an essential part in the causation of coronary occlusion, while intramural hematoma associated or not with thrombosis, thrombosis associated with stenotic coronary sclerosis, and coronaritis were the contributing factors. The left descending branch was the preferred site of the occlusion, while the left circumflex branch was not involved. The results of the authors' studies, particularly the demonstration of coronary thromboses in nearly two thirds of the cases, are of considerable interest with respect to treatment of cardiac infarction with anticoagulants. Anticoagulants may not only prevent the formation of parietal thromboses but also have an effect on the coronary arteries by preventing the appositional growth of the coronary thrombi in the proximal direction. The advantages of the anticoagulant therapy may, therefore, overbalance the occasional disadvantages of a possible increase of intramural hemorrhages.

Semaine des Hôpitaux de Paris

29:2699-2750 (Sept. 18) 1953

Myoclonus Epilepsy of the Type of Dyssynergia Cerebellaris Progressiva of Hunt. R. Amyot.—p. 2699.

*Action of Methyl Androstenediol on Growth in Children. A. Netter and J. Chevallier.—p. 2704.

Gastric Tumors Invaginated into the Duodenum. C. Debray and Y. Muffang.—p. 2713.

Action of Methyl Androstenediol on Growth in Children.—Methyl androstenediol (17 α-methyl-Δ^5-androstene-3 β, 17 β-diol, steroid) is a hormone that when given in therapeutic doses has very weak androgenic properties and a strong stimulating effect on protein anabolism, thereby rendering it particularly suitable for treatment of simple retarded growth in children without accompanying sexual deficiencies. Results of the administration of dipropionate methyl androstenediol to 13 patients (8 boys and 5 girls) of from 6 to 17 years of age and of dipropionate androstenediol to one 22-year-old woman showed positive evidence of statural growth in 6, slight evidence in 4, and no evidence in 4. There was no premature fusion of the epiphyses. Ponderal growth occurred in five. Tolerance of the medicament was good in all patients; there was improvement of the psychic state in four; and appetite increased in two. The authors conclude that the stimulating effect on bone growth of the products used is undeniable, at least on a short-term basis, but that it is impossible to judge whether the final height is influenced by these hormones.

29:2757-2810 (Sept. 26) 1953

Techniques of Portacaval Shunts. P. Santy and P. Marion.—p. 2758.

Fibroadenia and Portal Hypertension: Contribution to Study of Banti's Syndrome. P. Croizat, L. Revol, M. Piauchu and Fayolle.—p. 2768.

Radiologic Study of Cardioesophageal Varices in Portal Hypertension. J. Papillon, F. Pinet and P. Marion.—p. 2775.

*Portal Obstruction. P. Marion.—p. 2781.

Indications for and Results of Portacaval Shunts in Cirrhosis of Liver. A. Vachon and A. Grivet.—p. 2790.

Portal Obstruction.—Banti's description in 1894 of a disease of the spleen characterized by fibroadenomatous splenomegaly has given rise to the incorrect grouping in a single syndrome of a number of different diseases manifested in this manner. Obstruction of the portal system constitutes one of the major diseases wrongly classified in this way. Of the 63 patients operated on by the author or a colleague for "Banti's syndrome" since 1948, 40 had portal obstruction and 23 portal hypertension, of which 4 cases were metafeteric and 19 of the type of Banti. Congenital stenosis of the portal vein is frequent in children, but its manifestations are often delayed until the 10th or 15th year. Inflammatory stenosis, such as that following appendectomy, and thrombosis of the portal vein are found in adults. Contrary to the belief of Whipple, Blakemore, and others that only intrahepatic block causes cirrhosis of the liver, the author finds that cirrhosis may be associated with these extrahepatic obstructions when compensatory portahepatic anastomoses are scarce and weak. The clinical manifestations of portal obstruction are hemorrhages due to the rupture of cardioesophageal varices, followed by painful hypersplenia and, very occasionally, ascites. Obstructions localized at the splenic vein are treated by simple splenectomy. Portal stenosis with residual hypertension after splenectomy requires an anastomosis of the splenic and renal veins. This operation has a very small percentage of relapses after three years. Splenectomy is not indicated for an obstruction of the portal vein because, if a relapse should occur, a splenorenal anastomosis is impossible and an anastomosis, whether direct or by graft, of the superior mesenteric vein and the vena cava is not always possible. Radiographic and manometric checking of the portal system should be practiced systematically during surgery for hemorrhages of splenic origin and before splenectomy whenever diagnosis of splenopathy is in doubt.

Settimana Medica, Florence

41:291-318 (July 15) 1953. **Partial Index**

*Experimental Studies on Fibrinolytic, Embololytic and Anticoagulant Effect of Intravenous Administration of Pancreatic Enzymes with Particular Reference to Lysis of Emboli in Pulmonary Arteries. F. Zini.—p. 304.

*Use of Hyaluronidase in Renal Lithiasis: Synthetic Critical Review. F. Timacci.—p. 312.

"Fibrinoclasi" on Emboli of Pulmonary Arteries.—"Fibrinoclasi" is a mixture of two pancreatic enzymes with a pronounced fibrinolytic and anticoagulant activity. In the author's experiments intravenous administration of the preparation caused lysis of the emboli that were localized in the pulmonary arteries of rabbits. He produced the emboli by injecting clots of blood that had been removed from the animal's heart into the marginal vein of its ear. Then he injected the fibrinolytic preparation diluted in isotonic sodium chloride solution very slowly into the same vein or into the heart. Doses of 20, 40, and 100 mg. were used. The coagulation time was prolonged and the plasma fibrinogen level was decreased 4 to 16 hours after the injection. The prothrombin time was markedly prolonged and the plasma accelerating factor was scarce. The fibrinolytic properties of the plasma were increased. After 24 hours there was a return to the initial values. Macroscopic and microscopic studies were made of the pulmonary arteries of the rabbits that had received 100 mg. of the preparation. Although there were no emboliform intravasal formations, there was evidence that the vessels had been impaired and that a phase of resumed function was following a state of particular nonspecific physiopathological impairment. But to obtain the lysis of the emboli, the preparation should be administered as soon as possible after the clots have formed. The preparation is much more effective on clots of recent formation. Because of its effects, the action of "Fibrinoclasi" resembles that of heparin more than that of bishydroxycoumarin (Dicumarol).

Hyaluronidase in Renal Lithiasis.—Administration of hyaluronidase is a new method for treating and preventing renal lithiasis. Its use is based on the concept that the colloids present in the urine prevent the precipitation of urinary crystalloids and a decreased concentration of urinary colloids is responsible for a greater tendency of the urinary crystalloids to precipitate and cause stone formation. Since it was found that the urinary colloidal activity is more pronounced in persons with a normal urinary apparatus than in patients with renal lithiasis, injections of hyaluronidase were made to increase the concentration of the colloids in the urine and thus prevent or arrest the formation of stones. The action of hyaluronidase in patients with renal lithiasis is indirect. Hyaluronic acid is released at the site of the injection; the connective barrier begins to reconstitute itself while the hyaluronidase action is dissipated. During this phase excess hyaluronic acid or a similar substrate passes into the blood, is excreted in the urine, and thus acts as a protective colloid. The author believes that to be effective the treatment should be continued indefinitely because of the transitory action of the enzyme. But, since a prolonged administration of hyaluronidase may cause side-effects or produce an increased serum concentration of antihyaluronidase that would render useless the injected enzyme, he suggests the use of hyaluronic acid or chondroitin sulfuric acid. These have the same effect on the urine colloidal activity as subcutaneous injections of

V 1
195

hyaluronidase, but, since they do not have an antigen power nor the characteristics of haptens, their parenteral or intravenous administration could be continued indefinitely without harm to the organism.

South African Medical Journal, Cape Town

27:705-732 (Aug. 22) 1953. **Partial Index**

Recent Advances in Virus Diseases. T. H. Weller.—p. 705.
Man and His Eating Utensils: Suggested Approach to Control of Utensil Diseases. A. L. Ferguson.—p. 713.
*Effect of Thyroid Extract in Hypertension. B. A. Bradlow, M. McGregor, M. M. Zion and T. H. Bothwell.—p. 717.

Thyroid Extract in Hypertension.—Bradlow and associates attempted to reproduce the encouraging results that Menof obtained with thyroid extract in many hypertensive subjects. They gave thyroid extract to 22 patients with hypertension after a control period of placebo administration. Two out of 18 patients had a decrease in diastolic pressure of more than 15 mm. Hg on no treatment or on placebo therapy, while in 2 out of 25 trials there was a decrease in diastolic pressure of more than 15 mm. Hg during thyroid therapy. It does not appear, therefore, that thyroid extract in the dose used has any dramatic effect, beneficial or otherwise, on the level of blood pressure or on the symptoms of essential hypertension.

27:733-756 (Aug. 29) 1953

*The Value of Penicillin and Sulphadiazine Used Separately and in Combination in 200 Cases of Pneumonia. L. D. Erasmus.—p. 733.
Gastro-Oesophageal Regurgitation: Its Incidence and Relation to Symptoms. L. Werbeloff and C. Merskey.—p. 739.
Modern Trends in Pharmacology and Therapeutics in Relation to Nutrition. D. G. Steyn.—p. 741.
New Preparations and Appliances: A Portable Thermometer Stand. I. Mirvish.—p. 747.

Penicillin and Sulfadiazine in Pneumonia.—Two hundred Bantu patients with pneumonia were divided into three groups. Uniformity was maintained with regard to sex, age, duration of illness before admission, temperature at beginning of treatment, and anatomic distribution of lesions. Those of the first group were treated with penicillin, those of the second with sulfadiazine, and those of the third with both. The evidence gained by tabulating the mean duration of pyrexia in the three groups indicates that penicillin and sulfadiazine are probably equally effective in the treatment of pneumonia and that there is nothing to be gained by administering both simultaneously. In fact, the figures, so far as they go, indicate that this practice may even be harmful. The well-known additive effect of penicillin and sulfadiazine in vitro is not reflected in the results obtained in the present study. In the group treated with penicillin, delayed resolution of the disease showed a relation to the insensitivity in vitro of the causative bacteria to the treatment prescribed. This relationship was seen to a lesser extent in the other two groups. The majority of cases with resistant bacteria in the sulfadiazine group resolved rapidly, however; this phenomenon was not seen in the other groups. It appears that sensitivity tests in vitro are of little value in predicting the outcome of any particular case when sulfadiazine is employed, but may be of value in cases treated with penicillin. All things considered, the results of treatment with penicillin appear to be slightly superior to those obtained with the other two methods.

Tuberkulosearzt, Stuttgart

7:507-572 (Sept.) 1953. **Partial Index**

Therapeutic Use of Aerosols in Nonspecific Bronchopulmonary Diseases. J. M. Kapferer.—p. 508.
*Development of Resistance and Therapeutic Effect with Isoniazid After Three and Six Months of Treatment. G. Berg, G. Herholz and G. Meissner.—p. 519.
Destructive Effects on Erythrocytes and Patients with Tuberculosis. H. Böttner and B. Schlegel.—p. 525.
Roentgenologic Differential Diagnosis of Multiple Coarse Nodular Pulmonary Foci. H. Braun and P. Weicksel.—p. 533.

Development of Resistance to Isoniazid.—Berg and co-workers investigated the reduction in the sensitivity of tubercle bacilli to isoniazid (isonicotinic acid hydrazid). The development of resistance during the first three months of isoniazid treatment could be ascertained on 119 patients; the dependence of the appearance of resistant strains on the form of tuberculosis could be studied on 183 patients; and for ascertaining the effect of a six month course of isoniazid therapy, 80 patients were available. It was observed that bacteriological resistance against isoniazid develops rather rapidly during the first three months of therapy; it increases moderately during the second three months. It develops with greater rapidity and greater frequency in patients with chronic tuberculosis who have larger pulmonary cavities than in patients with new exudative forms of tuberculosis. There is a close statistical relationship between reduction in sensitivity of the tubercle bacilli and the failure of therapy. If treatment is continued beyond the first three months, however, it does not necessarily follow that the presence of strains that are still sensitive implies a favorable prognosis for the carrier nor does presence of resistant strains necessarily imply an unfavorable prognosis. After the patient has been treated with isoniazid for three months without much success, the clinician should ask himself whether it would not be advisable to resort to collapse therapy. If bacterial resistance remains constant, it is advisable either to change to another chemotherapeutic substance or to try a combination of chemotherapeutic and antibiotic drugs. It should be remembered that the main effect of treatment with isoniazid is obtained during the first three months, and, if it has not materialized then, it can hardly be expected later on.

Ugeskrift for Laeger, Copenhagen

115:1139-1170 (July 23) 1953. **Partial Index**

*Treatment of Acquired Hemolytic Anemia with ACTH and Cortisone. H. Letman.—p. 1139.
Immunohemolytic Anemia. L. K. Christensen.—p. 1145.
Hemolytic Anemia in Hepatic Disorders. L. K. Christensen.—p. 1152.
Cation Exchange Method for Determining Free Hydrochloric Acid in Stomach Without Intubation. E. Hofgaard.—p. 1154.
Prophylactic Treatment of Migraine Tested with New Preparation b-(2-Diethyl-amino-Ethoxy) Naphthalin. T. D. Nielsen.—p. 1156.
Case of Air Embolism Treated with Procaine Intravenously. K. M. Jensen.—p. 1159.

Treatment of Acquired Hemolytic Anemia with Corticotropin and Cortisone.—Four patients with immunohemolytic anemia were treated with corticotropin and cortisone with good results. In the first two patients symptoms returned after a short course of treatment, but remission was maintained for seven and six months, respectively, by the administration of 50 mg. of cortisone daily, and three months after treatment ended there had been no recurrence. In the other two patients recovery seemed to occur after a short course of corticotropin and cortisone treatment. Letman states that these cases together with 24 from the literature bring to 28 the number of cases published in which immunohemolytic anemia has been treated with corticotropin and cortisone, with satisfactory immediate results in 25. Most cases seem to recur after a short course of treatment, but with long-continued cortisone treatment in moderate doses the remission can probably be maintained in many cases. If not, splenectomy must be done, but not until the patient has been brought into a satisfactory condition with corticotropin or cortisone. Parallel with the treatment and improvement in the hemolytic anemia there was a reduction in autoimmunization and in osmotic fragility.

115:1203-1236 (Aug. 6) 1953. **Partial Index**

Guidance in Treatment of Respiratory Complaints in Poliomyelitis. B. Ibsen.—p. 1203.
Prediction of Epidemic Wave of Poliomyelitis. H. Petersen.—p. 1207.
Problems of Poliomyelitis Infection. A. Maag.—p. 1212.
*Leiodystonic Syndrome in Indigenous Disease. P. H. Pock-Steen.—p. 1216.

Leiodystonic Syndrome in Indigenous Diseases.—In different chronic disorders, mainly enterogenic toxemia, a symptom complex has been manifested that Pock-Steen designates as the leiodystonic syndrome. It corresponds in all details but in different intensity to the tropical disease dystonia. Four typical cases are described, in which treatment with moderate doses of corticotropin (ACTH) gave good results. All in all, a score of such cases have been observed. The syndrome appears as a nosographic entity and includes neurocirculatory, gastrointestinal, and psychasthenic phenomena. It is the clinical expression of glucocorticoid deficiency and differs from Addison's

disease, where mineralocorticoid deficiency dominates the picture. The prognosis is good. The most important symptoms—hypotension, hypoglycemia, reduced basal metabolism, hypovitaminosis B_2, mydriasis and psychasthenia—seem to depend partly on insufficiency of the adrenal cortex and partly on a secondary compensatory hyperadrenalinemia.

115:1237-1266 (Aug. 13) 1953. **Partial Index**

*Epidemic (?) Vegetative Neuritis. T. Fog.—p. 1244.
Acute Cryptogenic Infantile Hemoplegia: Review and Case with Noteworthy Electroencephalographic Findings. S. Brandt.—p. 1251.
Changed Model of Krogh's Metabolism Apparatus: Preliminary Clinical Experimental Results. B. Strange.—p. 1255.

Epidemic (?) Vegetative Neurosis.—Fog reports 10 cases of a disorder characterized by sudden onset, headache, and often malaise and vomiting. In seven cases moderate fever was noted. There were painful paresthesia in the extremities with visible and often pronounced hyperhidrosis, together with symptoms of vascular spasm in the extremities, psycholability, and fatigue. Although precordial pain was frequent, repeated electrocardiograms revealed no changes. The general condition was good. The cerebrospinal fluid, examined in five cases, was normal. The cases occurred during a poliomyelitis epidemic, but paralysis appeared only in one instance, in which the reflexes were lively. The course was marked by fluctuations that gradually decreased and disappeared. In six cases there were marked recurrences at five or six week intervals. The only designation that seems to the author to cover the condition is vegetative neurosis, probably epidemic.

115:1267-1292 (Aug. 20) 1953. **Partial Index**

*Chemotherapy in Tuberculosis. K. A. Jensen, K. Tørning, J. Haarhøj and I. Klaer.—p. 1267.
Fibromatosis of Plantar Fascia. F. Bang and J. Ernst.—p. 1272.
Alloplastic Operation on Hip According to Judet and Pertrochanteric Osteosynthesis in Same Session. R. Movin.—p. 1277.

Chemotherapy in Tuberculosis.—The introduction of isoniazid marks an important advance in the treatment of tuberculosis, but tubercle bacilli rapidly become resistant to the agent when it is applied alone, and, further, there is danger of home treatment because treatment with isoniazid alone is so easily carried out. In order to prevent this valuable agent from becoming ineffective through misuse, Jensen and his associates emphasize that treatment of pulmonary tuberculosis with isoniazid alone is contraindicated except in the case of the few patients in whom the tubercle bacilli are in advance resistant to both streptomycin and *p*-aminosalicylic acid (PAS) and where treatment is required. A long-continued effect of streptomycin or isoniazid can be attained by the combination of each of the substances with *p*-aminosalicylic acid. Combined treatment with all three substances is considered the most effective chemotherapy in tuberculosis. In treatment of patients with tubercle bacilli resistant to streptomycin the combination of isoniazid and *p*-aminosalicylic acid may be recommended, but it must be borne in mind that in about one-fourth of the patients with cavernous pulmonary tuberculosis, tubercle bacilli resistant to isoniazid appear after three months' treatment.

Wiener klinische Wochenschrift, Vienna

65:825-840 (Sept. 25) 1953. **Partial Index**

*Treatment of Bechterew's Disease with Thorium X. P. Erlacher.—p. 825.
Formal and Causal Genesis of So-Called "Idiopathic" Aneurysm of Aortic Sinus (Sinus of Valsalva). L. Kucsko.—p. 826.
Problem of Surgical Treatment of Angina Pectoris. W. Weissel, M. Wenzl and G. Wense.—p. 831.

Treatment of Bechterew's Disease with Thorium X.—Thorium X, a radioactive isotope obtained from radiothorium, which gives off only alpha rays and has a half value period of 3.64 days, was used for the treatment of 10 men and 4 women with ankylopoietic spondylarthritis. Men predominated in a ratio of 3 to 1 in contrast to other reports with a ratio of 5 to 1. A buffered solution of 200 electrostatic units of thorium X was injected intravenously once a week for 10 to 12 weeks. Of the 14 patients, 4 became free of complaints, 5 were considerably improved, 1 was a therapeutic failure, and 4 have not been followed up long enough for evaluation of results. The increased erythrocyte sedimentation rate showed a definite tendency to approach normal and the thoracic expansion was increased by 2, 3, and 4 cm. A pain reaction was noted that first occurred in the area most recently involved by the disease and only later in the areas with foci of longer duration. These pains gradually subsided and finally disappeared completely. The patients were able to move more freely; one patient was able to put on his shoes by himself. These satisfactory results corresponded with those reported from the orthopedic clinic of the university in Münster, Germany, by Pitzen whose therapeutic prescriptions were closely followed by the author. Of 120 patients treated by Pitzen between 1948 and 1950, 80 were reexamined after one year; 60 were free of complaints, 18 were considerably improved, and only 2 were therapeutic failures. The thoracic expansion was increased on the average from 2.37 cm. before the treatment to 4.35 after the treatment, with an occasional increase up to 8 cm. The treatment should be applied only to inpatients and blood cell counts should be taken regularly. A drop in leukocytes below 4,000 should be considered as a warning sign to reduce the dose of the thorium X.

Zeitschrift für klinische Medizin, Berlin

150:407-498 (No. 5) 1953. **Partial Index**

*Epinephrine Ketosis in Diabetes Mellitus. F. Müller.—p. 407.
Fragility of Erythrocyte and Vascular Diseases. E. Perlick and H. Lutz.—p. 421.
Diurnal Course of Respiratory Frequency. G. Hildebrandt.—p. 433.
Rhythmic Functional Order of Pulsation and Respiration. G. Hildebrandt.—p. 445.
Hyperinsulinism in Adenocarcinoma of Pancreas with Function of Metastases. O Bode and J. Probst.—p. 469.
Clinical Experiences with Triethylenemelamine (TEM) in Treatment of Tumor-Like Blood Diseases. H. E. Bock, E. Kirberger and U. Woelffer.—p. 482.

Epinephrine Ketosis in Diabetes Mellitus.—Müller shows that, whereas epinephrine tolerance tests have been used widely in the study of the carbohydrate metabolism, epinephrine so far has not been employed in testing fat and ketone metabolism. It has long been known that epinephrine reduces the fat content and increases the ketone bodies in the blood, however, with the customary dosage of 1 mg. of epinephrine, injected subcutaneously, ketosis generally does not become evident in the healthy nonfasting person, but it does become manifest whenever the person shows a tendency toward ketosis. It intensifies or makes evident fasting or exertion ketosis, exogenic ketosis resulting after the intake of large amounts of fat, and, of course, the metabolic ketosis of the diabetic patient. Fifty-seven epinephrine tests were made in 33 patients with diabetes mellitus. It was found that after the subcutaneous injection of 1 mg. of epinephrine the fat metabolism of the diabetic patient, even if his sugar metabolism is well adjusted, reacts generally with an increase in blood ketone bodies, but the ketone content generally does not exceed 5 mg. per 100 cc. of blood. Diabetic patients with a decided tendency toward the formation of acetone can be readily detected with the aid of this epinephrine test. Their ketone curves rise much higher, even when their "morning ketone" was normal and their metabolism well adjusted, and the prompt reduction to normal values in four or five hours is lacking. Epinephrine-induced ketosis may prove valuable also in adjusting diabetic patients to a suitable management. However, the epinephrine test cannot be used for the detection of endocrine variants and for differentiating mild and severe forms of diabetes mellitus. It could be demonstrated that glycogenolysis in the liver and ketogenesis are not necessarily interconnected metabolic processes and that the earlier concepts of a retarded fat metabolism, which does not participate in acute combustion processes, can no longer be accepted. It seemed probable that epinephrine first inhibits the combustion of glucose and of ketone bodies in the periphery, and only after the epinephrine effect has been equalized by counter regulation, does intensified combustion begin on an elevated metabolic level.

BOOK REVIEWS

Synopsis of Medical Parasitology. By V. E. Brown, Ph.D., Assistant Professor of Biology, Marquette University, Milwaukee. Paper. $3.50. Pp. 109, with 103 illustrations. V. E. Brown, 512 N. 13th Street, Milwaukee, 1953.

This book is perhaps the first of its kind to be published. It can best be described as a reference manual for the laboratory identification of parasites found in human beings. The subject matter is divided into 31 chapters according to the particular genus, species, or form of each parasite. Each chapter includes a brief discussion of the specified phase of the subject, a list of pertinent references, and a series of drawings to illustrate the morphology of the parasite and its life cycle. The illustrations constitute the most important feature of the book and consist of uncolored reproductions from structurally precise scale drawings showing the microscopic anatomy of the various cyclic forms as they are known to occur in man, vector, and intermediate or definitive host. The external appearance of certain insects or animals involved as vectors, intermediates, or hosts is also illustrated. The illustrations of parasites are carefully labeled and accompanied by a key to the identity of all important anatomic features. The author intends the publication for students who cannot afford and find it inconvenient to use the large number of texts on the subject that should be consulted in the laboratory. From that standpoint, the book will be useful as a teaching supplement to lectures and textbooks on the subject. A general index included at the end increases the usefulness of the manual as a reference. Some of the entries refer to names that are not listed in the text. This is likely to be confusing to beginners.

This publication will be useful as a supplement to other sources of instruction, chiefly from the point of view of laboratory diagnosis.

Plant Proteins in Child Feeding. By R. F. A. Dean. Medical Research Council special report series no. 279. Paper. $2.25; 10s. Pp. 163, with illustrations. British Information Service, 30 Rockefeller Plaza, New York 20; Her Majesty's Stationery Office, P. O. Box 569, London, S.E.1, 1953.

In many parts of the world it is difficult or impossible to obtain sufficient milk for the feeding of infants and children. Therefore, the development of foods that could be prepared from indigenous raw materials is of great practical value. During the years 1946 to 1949, Prof. R. A. McCance of the University of Cambridge headed a Medical Research Council team studying undernutrition in Germany. Dr. Dean, a member of this group, investigated the value of mixtures of plants as additions to children's diets. His findings are reported in this book, which is divided into two parts. The first reviews the problems in the use of plant proteins for human nutrition, and the second gives the actual data obtained in Dr. Dean's studies and his recommendations for future work.

The children, who were living in orphanages, varied in age from 6 months to 11 years and were fed basic diets containing little animal protein for periods of 8 to 24 weeks. These were supplemented with cow's milk or mixtures of cereal and soya. It was found that a large portion of the children's diets could consist of the cereal and soya mixture with no adverse effect on growth. In the meals of children below the age of one year, about half the total amount of milk could be replaced with the plant proteins. The replacement of almost all of the milk with plant proteins could be accomplished with the older children, although for optimum growth a small amount of milk seemed to be necessary. Dr. Dean concludes that it may ultimately be possible to provide mixtures of foods, derived entirely from plant sources, that would equal milk in nutritive value. Pediatricians and others who are concerned with the feeding of infants and children in areas where milk is not readily available will find this publication valuable. Other physicians and students interested in nutrition in general can glean much from the discussion of the use of proteins of plant origin in the human diet.

These book reviews have been prepared by competent authorities but do not represent the opinions of any official bodies unless specifically so stated.

Die Nahbestrahlung. Von Henri Chaoul und Felix Wachsmann, Dozent für medizinische Physik an der Universität Erlangen. Second edition. Cloth. 39 marks. Pp. 225, with 304 illustrations. Georg Thieme, Diemershaldenstrasse 47, (14a) Stuttgart-O; American agent, Grune & Stratton, Inc., 381 Fourth Ave., New York 16, 1953.

This book offers a complete and up-to-date description of the techniques used in applying soft roentgen radiation to superficial or to surgically exposed lesions (plesio-roentgentherapy, contact roentgentherapy, and low-voltage near-distance therapy). Well illustrated with photographs of apparatus and cases, it contains much valuable quantitative information in the form of tables and diagrams. Radium and the radium-substitutes recently provided by the uranium pile are excluded from the discussion except for purposes of comparison. The text is well written, the printing excellent, and the extensive bibliography includes Italian, French, English, German, and American work. The use of such abbreviations as FHA and GHWT is annoying. In some places their meaning is evident from the context, but in others it is not; often the reader could be saved time and effort by a single entry in the index leading to the passage where the abbreviation is explained or first used. Aside from this and a few small errors in the bibliography, the book deserves high praise. It will probably prove to be a classic in its field.

Vegetative Konstitutionstherapie. Von Otto Hauswirth, Facharzt für physikalische Medizin in Wien. Cloth. $5.45. Pp. 298, with 23 illustrations. Springer-Verlag, Mölkerbastei 5, Wien 1, 1953.

Conceived as a pioneer work to explore the relation of constitution to therapy, this book begins with some undeniable anatomic facts about the autonomic nervous system, moves on to the shaky ground of human typology, and then attempts to explain practically everything in pathology, pharmacodynamics, and physical therapy in terms of vagotonia and sympathicotonia. The effects of various antibiotics are explained by their assumed effects on the nerves (pages 146 to 150). Sunlight (page 256) is stated to cause a discharge of electrons from the skin by the familiar process of photoelectric emission, so that the vagus loses its charge and lets the sympathetic nerves get the upper hand; hence one need only ask a patient whether he tolerates sunlight, for if he does he is a vagotonic. There are no indications that the author appreciates the importance of contratests or understands statistical methods; his ideas are based on a diligent but uncritical exegesis of about 700 items of medical literature listed in his bibliography. This book, which is not recommended, makes one wish for a "new deal" in medical literature.

The Conquest of Plague: A Study of the Evolution of Epidemiology. By L. Fabian Hirst, M.D. With foreword by Lieut.-General Sir William Macarthur, K.C.B., M.D., F.R.C.P. Cloth. $11. Pp. 478, with 26 illustrations. Oxford University Press, 114 Fifth Avenue, New York 11; Amen House, Warwick Sq., London, E.C.4, 1953.

This book is not a history of plague epidemics or a systematic textbook. It begins with a brief account of traditional beliefs about the cause of plague, then traces the main source of human infection to the ubiquity of rats and fleas. It ends by showing how recent advances in our knowledge of rats and their parasites has led to the conquest of this deadly disease. The author, who has had long experience with this disease in the Middle and Far East, has written in a lucid style that should attract lay persons as well as physicians. The book is comprehensive and contains an adequate bibliography at the end of each of its four parts. Four appendixes give technical information considered too detailed for the main text. There is an author index and a subject index.

Hunted Heretic: The Life and Death of Michael Servetus, 1511-1553. By Roland H. Bainton. Cloth. $3.75. Pp. 270, with illustrations. Beacon Press, 25 Beacon St., Boston 8, 1953.

This is a biography of the 16th century scholar, Servetus, who, like his contemporaries of the Renaissance, was thirsty to conquer all fields of knowledge. He was a distinguished student of the Bible, a theologian, geographer, physician, physiologist, and a master of ancient languages. Although such a combination is very rare today, it must be remembered that in those days theology, philosophy, physiology, and psychology were not compartmentalized but were all a part of advanced learning. As a result, the practice of medicine appears to have been but one of several sidelines for Servetus. The author points out that Servetus discovered that the blood circulates through the lungs, a fact that Galen had not understood, but most of the book is devoted to a discussion of the religious controversies that finally led to Servetus' being burned as a heretic. The author states that Servetus "was never quite sure whether he was talking the language of physiology or religion and, for that reason, he has become difficult to comprehend in an age of secularization of science. For [him] there was only an enhancement of natural processes in ascending from respiration to inspiration, generation to regeneration, from sight to insight, from birth to new birth of the spirit." In another passage the author makes the profound observation that "two religions can exist side by side amicably only if they think they can." This book will appeal to those who like to browse in history. At the end there is a chronology, a bibliography, annotations, and an index.

The Physics of Radiation Therapy. By Harold Elford Johns, M.A., Ph.D., F.R.S.C., Professor of Physics, University of Saskatchewan, Saskatoon, Canada. Publication number 116, American Lecture Series, monograph in Bannerstone Division of American Lectures in Radiation Therapy, edited by Milton Friedman, M.D., Associate Professor of Radiology, New York University Post-Graduate Medical School, New York. Cloth. $8.50. Pp. 286, with illustrations. Charles C Thomas, Publisher, 301-327 E. Lawrence Ave., Springfield, Ill.; Blackwell Scientific Publications, Ltd., 49 Broad Street, Oxford, England; Ryerson Press, 299 Queen Street, W., Toronto 2B, 1953.

The author's purpose is to explain, for students and physicians, the physical principles basic to an understanding of radiotherapy. The first chapter on the nature of matter and of radiation is followed by six chapters on roentgen rays, one on energy absorption, two on radium, one on high energy devices such as the betatron, and one on artificial radioactivity with emphasis on the therapeutic use of materials like cobalt 60 that emit gamma rays. Two appendixes supply a wealth of precise technical information in the form of tables and diagrams. There are many good illustrations, a subject index, and an author index, and the book as a whole is legible and attractive. It can be recommended both as an introduction for students and as a reference work for specialists using ionizing radiations therapeutically.

History of the Second World War: United Kingdom Medical Series. Editor-in-Chief: Sir Arthur S. MacNalty, K.C.B., M.D., F.R.C.P. The Emergency Medical Services. Volume II: Scotland, Northern Ireland and the Principal Air Raids on Industrial Centres in Great Britain. Edited by Lieut. Colonel C. L. Dunn, C.I.E., I.M.S. Cloth. 50s. Pp. 492, with 40 plates. Her Majesty's Stationery Office, P. O. Box 569, London, S.E.1, 1953.

Volume 2 of this historical series is in three parts. Parts 1 and 2 show that the emergency medical services adopted in Scotland and Northern Ireland followed a pattern similar to those that proved their worth in England and Wales. The latter were briefly mentioned in a review of volume 1 published previously in THE JOURNAL (Aug. 15, 1953). Great encouragement is to be derived from reading these two volumes, as they show the remarkable adaptability possible during wartime in a highly complex society crowded together in large cities. Scotland was subjected to a greater number of air attacks than is generally known, and some of them were severe. There were very few enemy air attacks in Northern Ireland except for Belfast, but, during one of the four raids on that city, more persons were killed in about six hours than in any day raid in England made outside of the London area. Part 3 of this volume gives a representative picture of the various emergency medical services in action under the strain of heavy air attacks by the enemy; it also includes accounts of some of the "Baedeker" raids in 1942, when the enemy began heavy attacks on the cathedral cities of Exeter, Bath, Norwich, York, and Canterbury. Hitler threatened to ruin every cathedral city mentioned in "Baedeker." In this section of the volume it is said that the emergency medical services functioned most efficiently. Civil defense workers will be interested not only in the effectiveness of the Emergency Medical Services but also in some of the mistakes made. For example, on page 459 in the account of the raids on Belfast, it is said that in the larger raids, the mistake made by the control center was the calling of excessive resources from outside areas. At one time more than 120 first aid parties and ambulances were in a most vulnerable area in the center of the city. Most of the country parties called into the city had nothing to do. It was a mistake to put first aid posts in the "externs of hospitals." The result was that, during the raids, the externs became filled with the wounded, the dying, and the dead, and the actual work for which the first aid post was intended could not be carried out efficiently. The number of casualties from air raids in the London area from September, 1939, to June, 1942, is tabulated on page 210. The total number killed is given as 20,102, the injured (detained in hospitals) as 26,054, and the slightly injured as 47,046. These figures are only approximate because after heavy raids many fatalities were not discovered for days and others had to be eventually recorded as missing, presumed dead. There were also hundreds of fragments of human remains from which it was not possible to make any identification.

While this volume was prepared under the direction of an editorial board appointed by his Majesty's Government, the authors and the editors alone are responsible, it is said, for the opinions expressed. Just where this responsibility lies is a little difficult to determine because of the numbers who took part in preparing this volume. On the jacket and the flyleaf it is said to have been edited by C. L. Dunn. On a following page are the names of many who served on the editorial board, the chairman of which was Sir Cyril Flower. On another page are the names of those who served on the editorial committee, of which Sir Arthur S. MacNalty was chairman.

May's Manual of the Diseases of the Eye for Students and General Practitioners. Edited by Charles A. Perera, M.D., Associate Clinical Professor, College of Physicians and Surgeons, Columbia University, New York. Twenty-first edition. Cloth. $6. Pp. 512, with 378 illustrations. Williams & Wilkins Company, Mount Royal and Guilford Aves., Baltimore 2, 1953.

Adhering to the original purpose, the author has given us a simple, lucid, and concise text for medical students and general practitioners. He has revised each chapter and has added some new color plates. Future editions should omit some of the more obsolete forms of treatment such as the use of the copper sulfate stick in the treatment of trachoma. Each chapter has a short description of the normal anatomy and physiology of the conditions described. Nothing that is still of a controversial nature or in a semi-experimental stage has been included. The book should continue to be very popular, especially with medical students.

Elementary Pathological Histology. By W. G. Barnard, F.R.C.P., Professor of Pathology, University of London, St. Thomas's Hospital Medical School, London. Third edition. Cloth. 17s.6d. Pp. 77, with 185 illustrations. H. K. Lewis & Co., Ltd., 136 Gower St., London, W.C.1, 1953.

No major changes are made in the revision of this guide for students beginning elementary general pathology. Accordingly, concepts expressed in previous editions are continued despite recent changes in generally accepted viewpoints. The material illustrates the histology of the three principal pathological processes: inflammation, degeneration (retrogressive changes), and tumors. The treatment is general, in the belief that, from this understanding, the histology of special pathological lesions can be understood. The photomicrographs are average in quality, and the drawings are good. It is doubtful that the book will be used to any extent by beginning students of pathology in this country.

QUERIES AND MINOR NOTES

TRANSFUSION REACTIONS

To the Editor:—*Regarding the use of isotonic and dilute sodium chloride solutions in starting blood transfusions, is it hazardous to use 5% dextrose in distilled water for this purpose? Is it safer to use saline solution with or without 5% dextrose for this purpose?*

T. F. Brinton, M.D., Eugene, Ore.

Answer.—It is inadvisable to administer dextrose solutions with citrated whole blood. De Gowin, Hardin, and Alseuer (Blood Transfusion, Philadelphia, W. B. Saunders Company, 1949, p. 278) have called attention to the danger of extravascular hemolysis resulting from the mixture of stored blood and dextrose solutions. Although the clumping that occurs in a mixture of dextrose solution and citrated whole blood is reversible, Wilson (*Am. J. Clin. Path.* **20**:667, 1950) has reported a transfusion reaction traceable to this phenomenon. Dreyfus and Salmon (*Presse méd.* **60**:845, 1952) have also pointed out the danger of clumping and of increased fragility of red blood cells exposed to dextrose solutions. They have presented results of in vitro and in vivo studies to support their conclusion that the practice of giving simultaneous infusions of dextrose solutions and whole blood should be abandoned.

SENSATION OF BURNING IN ESOPHAGUS AFTER GASTRECTOMY

To the Editor:—*A patient who had a total gastrectomy for carcinoma a year ago with excellent results has suffered ever since with a constant burning throughout the esophagus. He is at work, feels well, and does not gain weight. Can you suggest an explanation for this symptom?*

M.D., California.

Answer.—Sensations of burning in the esophagus following total gastrectomy are often due to the regurgitation of bile and duodenal secretions into the lower esophagus and even occasionally into the pharynx. This regurgitation is most likely to occur when the lower end of the esophagus has been anastomosed to the side of the first part of the jejunum without an accompanying enteroenteric anastomosis lower down. The disagreeable symptoms usually disappear in time and are relieved somewhat if the patient sleeps with the head and shoulders somewhat elevated. The oral administration of bismuth preparations or of aluminum hydroxide gel (Amphojel) sometimes gives marked relief.

DUPUYTREN'S CONTRACTURE

To the Editor:—*I should like to know the present concepts regarding the causes of Dupuytren's contracture and regarding the role of working conditions as an aggravating factor. What supportive therapy is of value? Is corrective surgery advisable and at what stage? Is it advisable for such men to continue to work, considering work as a natural physiotherapeutic exercise?*

P. Guiraud, M.D., New York.

Answer.—The cause of Dupuytren's contraction is still a matter of uncertainty. There is no evidence that hard and vigorous use of the hand either causes or aggravates the condition. More than half the patients in carefully recorded series were men who did little work that involved active use of the hands. There is no medical treatment of value. The one certain method of correcting the condition is carefully performed, wide excision of the contracted fascia. The operation should be done if the overlying skin is becoming involved to such an extent that removal of the skin and subsequent skin grafting would be necessary to secure a good result or if a finger is being drawn down into the palm and the thickening and contraction of the fascia is producing a flexion contracture. Early operation in the absence of skin involvement and beginning contracture does not seem advisable, because similar development may occur in some other part of the hand, and a second operation may be required at a later date.

WILMS' TUMOR IN INFANT

To the Editor:—*An 8½-month-old white girl has undergone surgery for the removal of a Wilms' tumor (nephroblastoma) on the left side. Despite its removal, hypertension ranging from 200 to 250 mm. Hg systolic and 100 to 140 mm. Hg diastolic persists one week after surgery. The child has received sedation, has been given abdominal radiation on two occasions, and is on a low salt diet. She does not appear to be in acute distress. Her respirations and pulse rate are only slightly elevated. There is no mechanical error in recording the pressures, and other causes of hypertension have been "ruled out." In view of the relative asymptomatology, should attempts be made to bring the infant's tension down by the use of hydralazine (Apresoline) hydrochloride and related drugs? Should prophylactic digitalization be instituted in view of possible myocardial failure? What would be the approximate maintenance schedule if adrenolytic drugs were tried?*

Louis E. Imperiale, M.D., Brooklyn, N. Y.

Answer.—Wilms' tumor and hypertension have been associated in occasional patients. Pressure produced by involved lymph nodes about the renal pedicle may interfere with arterial blood supply and cause nephrogenic hypertension. The elevation of blood pressure associated with Wilms' tumor has not, however, been so great as that described in the query. Cerebral metastasis may cause great elevation of blood pressure associated with increase of intracranial pressure. Hypotensive drugs should be used cautiously. It is not likely that digitalization would help. Ganglionic blocking or adrenolytic drugs, if used, should be administered parenterally in minute doses at first and then in larger increments until an effect is evident. This would determine the initial maintenance requirement. Subsequent rise of blood pressure might necessitate larger doses after days or weeks of treatment.

RETINITIS PROLIFERANS

To the Editor:—*A man, aged 20, has had diabetes mellitus since the age of 3½. He has been growing progressively "blind" since October, 1952. He was seen by a prominent ophthalmologist, who told him that nothing could be done for him. His diabetes is controlled by 20 units of regular insulin three times daily. He is well developed and is 6 ft. (182.88 cm.) tall. Can you advise anything that may arrest the condition?*

Max D. Goldman, M.D., Brooklyn.

Answer.—The history of this patient suggests that retinitis proliferans has developed, which is the main ocular complication of diabetes in the young. In all patients with retinopathy, lack of control of the diabetes precedes the development of the ocular signs. Prophylaxis by adequate control of the diabetes with prevention of this complication is the only effective method of treatment. Unfortunately once the retinopathy has developed, there is no proved therapy of value. Through the years many remedies have been proposed and then discarded. Recently it has been suggested that vitamin B_{12} might be of value, together with x-ray therapy to combat the neovascularization of the retinitis proliferans. Testosterone propionate has been suggested, as have rutin and vitamin C, but their use is falling into discard.

The answers here published have been prepared by competent authorities. They do not, however, represent the opinions of any official bodies unless specifically so stated in the reply. Anonymous communications and queries on postal cards cannot be answered. Every letter must contain the writer's name and address, but these will be omitted on request.

THYROIDECTOMY

To the Editor:—*Is thyroidectomy indicated in the following case? A 30-year-old white woman is married and has three children. Her father and a niece have tuberculosis. On Jan. 9, 1953, while receiving an injection for varicose veins, she complained of nervousness and palpitation. Her basal metabolic rate was +26%. She was given strong iodine (Lugol's) solution for two weeks. Thyroidectomy was considered. The thyroid gland was barely palpable, and the rest of the physical examination revealed no pertinent abnormalities. X-ray examination, blood count, and urinalysis also revealed no abnormalities. On Jan. 30, 1953, her basal metabolic rate was +40. Her blood pressure was 125/80 mm. Hg, the pulse rate 132, and weight 112 lb. The patient is sensitive to smoking cigarettes; her pulse before smoking is 82 and after smoking 144, with little change in blood pressure. When she stopped smoking the nervousness and palpitation ceased and she felt fine. On March 18 the metabolic rate while she was under sedation with thiopental (Pentothal) was +4. On May 5 diagnostic currettage was done for profuse menstrual bleeding. On May 8 the metabolic rate was +38 and she was placed on propylthiouracil therapy, 300 mg. daily. On July 8 the metabolic rate was +24 and she weighed 114 lb. She felt well and had no symptoms. The blood pressure was 120/75 mm. Hg and the pulse 84. The patient has a definite dread of the procedure for determining the basal metabolic rate.*

Carl B. Adams, M.D., Adams, N. Y.

Answer.—The clinical history and the objective findings in this patient do not reveal much conclusive evidence for hyperthyroidism. Little importance can be attached to the basal metabolic rate determination in a patient who is as excitable and resistant to the basal metabolism procedure as this one appears to be. Furthermore, it is clear that at times she feels well even when her basal metabolism is reported high. In many patients mild hyperthyroidism like this is well controlled by propylthiouracil and after a year of treatment will remain in remission indefinitely. Certainly unless a more definite diagnosis can be made, utilizing additional laboratory procedures such as determination of the cholesterol and protein-bound iodine levels and tracer determinations with radioactive iodine, there is no indication at this time for operation. Since many thyroids are removed unnecessarily in the treatment of symptoms suggesting, but not arising from, hyperthyroidism, it is important that there be strong objective evidence of hyperthyroidism before definitive treatment is given.

MULTIPLE MYELOMA

To the Editor:—*Is a total protein value in excess of 9 gm. per 100 cc. with more than 3 gm. of globulin indicative of multiple myeloma? Would a total protein level of 4.5 gm. per 100 cc., with 4.1 gm. of albumin and 0.4 gm. of globulin, necessitate cancellation of surgery (gallbladder)? Is determination of total protein a routine preoperative procedure? What are the chief laboratory diagnostic criteria in multiple myeloma?* *M.D., New York.*

Answer.—It would be difficult to answer the first part of this question without knowing the exact value of the globulin. In multiple myeloma there is commonly a reversal of the albumin-globulin ratio, with a high globulin value while the albumin value remains within the limits of normal. Reversal of the albumin-globulin ratio with a high globulin level occurs in a number of other conditions and cannot be considered specific for myeloma. It is commonly seen in sarcoidosis, disseminated lupus erythematosus, and lymphogranuloma venereum, and it may occur in acute infections, blood dyscrasias such as leukemia, and kala-azar.

A total protein value of 4.5 gm. per 100 cc. with a globulin value of 0.4 gm. and an albumin value of 4.1 gm. is most unusual. It would be proper to question whether or not the method for protein determination was being properly carried out. While a globulin value of 0.4 gm. may be seen, one would expect to see with it a marked reduction in the albumin such as may occur in nephrosis. Determination of the total protein level is certainly not a preoperative procedure routinely. The chief laboratory diagnostic criterion in multiple myeloma is the examination of either sternal bone marrow or direct biopsy of the lesion with demonstration of myeloma cells.

TESTOSTERONE FOR OLDER MEN

To the Editor:—*What are the contraindications to the use of testosterone in small (10 mg.) daily doses? Are there any harmful results in the prolonged use in men when it seems to produce a sense of well-being and greater activity? Is this imaginary or real improvement? What daily dose is recommended?* *M.D., Arkansas.*

Answer.—It is assumed that the question refers to the use of testosterone in daily doses of 10 mg. by mouth in older men. The only harmful effect definitely established is the production of breast enlargement in a small percentage of men who receive it. It should not be used if there are any findings to suggest the presence of carcinoma of the prostate; however, carcinoma of the prostate cannot be induced by the use of testosterone. If carcinoma is present, its growth may be accelerated by the use of testosterone. A sense of well-being and greater activity are commonly observed in older men who take it and are probably not imaginary. The presence of actual improvement can be determined in many individual cases only by careful study.

CHLOROPHENOTHANE (DDT) IN WATER SUPPLY

To the Editor:—*Is it an accepted procedure to add chlorophenothane (DDT) to the water supply of a city? The water comes from springs in mountainous country and is collected in reservoirs. The proposed dosage of chlorophenothane is 10 gm. per cubic meter in biweekly intervals. What kind of parasites or pathogenic organisms would be eliminated? Would the domestic use of this water give rise to untoward reactions. Would the chlorophenothane content of used, stagnating water be sufficiently high to prevent development of Anopheles or Aedes aegypti mosquitoes? Is there any simple method of eliminating the chlorophenothane from the drinking water in private households?* *M.D., Haiti.*

Answer.—Treatment of an entire water supply of a community with chlorophenothane is not a recognized public health procedure. When mosquito control operations are in effect and it is necessary to kill mosquito larvae, it may be necessary to treat the surrounding edges of a water reservoir, particularly when vegetation or aquatic growth is present. This type of limited treatment has been effectively carried out using 0.05 to 0.1 lb. (24 to 48 gm.) of chlorophenothane per acre or by using about 6 gal. (24 liters) of no. 2 diesel oil per acre with a spreading agent.

Anopheline larvae will be found breeding in open type reservoirs and impounded water areas, but Aedes aegpti breed in artificial containers such as bottles, tin cans, flower vases, tanks, and cisterns. If the water supply is in cisterns, control may be obtained by applying a 1% residual chlorophenothane spray on the walls or linings of the cistern or applying a pyrethrum larvicide to the water surface.

The proposed dosage of 10 gm. per cubic meter of chlorophenothane is about 10 ppm. It is generally recommended that a concentration of 1 ppm in a drinking water supply will control Anopheles quadrimaculatus larvae. This concentration is not considered detrimental to the health of man. It is highly improbable that this insecticide will eliminate any parasite or pathogenic organism. It is felt that use of an activated carbon filter would remove much of the taste of fuel oil, chlorophenothane, or other foreign matter from the water supply. Additional technical information and guidance can be secured from the Communicable Disease Center, U. S. Public Health Service, 50 7th St., Atlanta, Ga.

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JOURNALS ABSTRACTED IN THE CURRENT MEDICAL LITERATURE DEPARTMENT, SEPTEMBER-DECEMBER 1953

Titles have been listed or abstracts made of important articles in the following journals in the Current Medical Literature Department of THE JOURNAL during the past four months. Any of the journals, except those starred, will be lent by THE JOURNAL to individual subscribers in Continental United States and Canada and to members of the American Medical Association and its student organization. No charge is made to members, but the fee for other borrowers is 15 cents in stamps for each periodical. Three journals may be borrowed at a time for a period not exceeding five days. Requests should be addressed to the Library of the American Medical Association. Thus most of these journals are accessible to the general practitioner.

*A. M. A. American Journal of Diseases of Children. Chicago.
*A. M. A. Archives of Dermatology and Syphilology. Chicago.
*A. M. A. Archives of Industrial Hygiene and Occupational Medicine. Chicago.
*A. M. A. Archives of Internal Medicine. Chicago.
*A. M. A. Archives of Neurology and Psychiatry. Chicago.
*A. M. A. Archives of Ophthalmology. Chicago.
*A. M. A. Archives of Otolaryngology. Chicago.
*A. M. A. Archives of Pathology. Chicago.
*A. M. A. Archives of Surgery. Chicago.
Acta chirurgica belgica. Brussels.
Acta chirurgica scandinavica. Stockholm.
Acta clinica belgica. Brussels.
Acta medica scandinavica. Stockholm.
Acta neurologica et psychiatrica belgica. Brussels.
Acta paediatrica. Stockholm.
American Heart Journal. St. Louis.
American Journal of Clinical Pathology. Baltimore.
American Journal of Digestive Diseases. Fort Wayne, Ind.
American Journal of Human Genetics. Baltimore.
American Journal of Hygiene. Baltimore.
American Journal of the Medical Sciences. Philadelphia.
American Journal of Medicine. New York.
American Journal of Obstetrics and Gynecology. St. Louis.
American Journal of Occupational Therapy. Milwaukee.
American Journal of Ophthalmology. Chicago.
American Journal of Orthopsychiatry. New York.
American Journal of Pathology. Ann Arbor, Mich.
American Journal of Physiology. Washington.
American Journal of Psychiatry. New York.
American Journal of Psychotherapy. New York.
American Journal of Public Health. New York.
American Journal of Roentgenol. and Radium Therapy. Springfield, Ill.
American Journal of Surgery. New York.
American Journal of Syphilis, Gonor. and Venereal Diseases. St. Louis.
American Journal of Tropical Medicine and Hygiene. Baltimore.
American Practitioner and Digest of Treatment. Philadelphia.
American Review of Tuberculosis. New York.
American Surgeon. Atlanta, Ga.
Anales de la Facultad de medicina de Montevideo. Montevideo.
Anesthesiology. New York.
Angiology. Baltimore.
Annals of Allergy. Minneapolis.
Annals of Internal Medicine. Lancaster, Pa.
Annals of Otology, Rhinology and Laryngology. St. Louis.
Annals of the Rheumatic Diseases. London.
Annals of Surgery. Philadelphia.
Antibiotics and Chemotherapy. Washington, D. C.
Archiv für Kinderheilkunde. Stuttgart.
Archiv für klinische Chirurgie. Berlin.
Archives of Disease in Childhood. London.
Archives of Physical Medicine and Rehabilitation. Chicago.
Archivio italiano di chirurgia. Bologna.
Archivos del Instituto de cardiología de México. Mexico, D. F.
Archivos de oftalmología. Buenos Aires.
Archivum chirurgicum neerlandicum. Arnhem.
Arizona Medicine. Phoenix.
Arquivos de neuro-psiquiatria. São Paulo.
Ärztliche Wochenschrift. Berlin.
Australasian Annals of Medicine. Sydney.
Australian Journal of Experimental Biology and Medical Science. Adelaide.
Australian and New Zealand Journal of Surgery. Sydney.
Bacteriological Reviews. Baltimore.
Beiträge zur klinischen Chirurgie. Munich.
Blood. New York.
Boletín de la Asociación médica de Puerto Rico. San Juan.
Boletín médico del Hospital infantil. Mexico, D. F.
Brain. London.
British Heart Journal. London.
British Journal of Cancer. London.
British Journal of Dermatology. London.
British Journal of Experimental Pathology. London.
British Journal of Industrial Medicine. London.
British Journal of Ophthalmology. London.
British Journal of Physical Medicine. London.
British Journal of Plastic Surgery. Edinburgh.
British Journal of Radiology. London.
British Journal of Surgery. Bristol.
British Journal of Tuberculosis. London.
British Journal of Urology. London.
British Medical Journal. London.
Bruxelles-médical. Brussels.
Bulletin of the Johns Hopkins Hospital. Baltimore.
Bulletin of the Los Angeles Neurological Society. Los Angeles.
Bulletin of the World Health Organization. Geneva.
California Medicine. San Francisco.
Canadian Journal of Medical Sciences. Ottawa.
Canadian Journal of Public Health. Toronto.
Canadian Medical Association Journal. Montreal.
Cancer. Philadelphia.
Cancer Research. Chicago.
Chinese Medical Journal. Peking.
Chirurg. Berlin.
Cincinnati Journal of Medicine.
Circulation. New York.
Circulation Research. New York.
Clinica. Bologna.
Clinica terapeutica. Rome.
Clinical Science. London.
Connecticut State Medical Journal. Hartford.
Cuore e circolazione. Rome.
Delaware State Medical Journal. Wilmington.
Deutsche medizinische Wochenschrift. Stuttgart.
Diabetes. New York.
Die Medizinische. Stuttgart.
Diseases of Chest. Chicago.
Documenta de medicina geographica et tropica. Amsterdam.
East Africa Medical Journal. Nairobi.
Edinburgh Medical Journal. Edinburgh.
Endocrinology. Springfield, Ill.
Fertility and Sterility. Philadelphia.
Folia cardiologica. Milan.
Fortschritte auf dem Gebiete der Röntgenstrahlen vereinigt mit Röntgenpraxis. Stuttgart.
Gastroenterology. Baltimore.
Gazeta médica portuguesa. Lisbon.
Gazzetta medica italiana. Milan.
Geriatrics. Minneapolis.
Giornale di clinica medica. Parma.
Glasgow Medical Journal. Glasgow.
GP (Journal of American Academy of General Practice). Kansas City, Mo.
Harefuah. Jerusalem-Tel Aviv.
Hawaii Medical Journal. Honolulu.
Hoja tisiológica. Montevideo.
Illinois Medical Journal. Chicago.
Industrial Medicine and Surgery. Chicago.
Irish Journal of Medical Science. Dublin.
Journal of Allergy. St. Louis.
Journal of the American Pharmaceutical Association. Washington, D. C.
Journal of Applied Physiology. Washington, D. C.
Journal of Arkansas Medical Society. Fort Smith.
Journal of Aviation Medicine. St. Paul.
Journal of Bacteriology. Baltimore.
Journal of Bone and Joint Surgery. Boston and London.
Journal of Clinical Endocrinology and Metabolism. Springfield, Ill.
Journal of Clinical Investigation. New York.
Journal of Clinical Nutrition. Allentown, Pa.
Journal of Clinical Pathology. London.
Journal of Endocrinology. London.
Journal of Experimental Medicine. New York.
Journal of the Florida Medical Association. Jacksonville.
Journal of Forensic Medicine. Cape Town.
Journal of Gerontology. St. Louis.
Journal of Hygiene. London.
Journal of Immunology. Baltimore.
Journal of the Indian Medical Association. Calcutta.
Journal of the Indiana State Medical Association. Indianapolis.
Journal of Infectious Diseases. Chicago.
Journal of International College of Surgeons. Chicago.
Journal of Investigative Dermatology. Baltimore.
Journal of the Iowa State Medical Society. Des Moines.
Journal of the Irish Medical Association. Dublin.
Journal of the Kansas Medical Society. Topeka.
Journal of the Kentucky State Medical Association. Bowling Green.
Journal of Laboratory and Clinical Medicine. St. Louis.

* Cannot be lent.

Journal of Laryngology and Otology. London.
Journal of the Maine Medical Association. Portland.
Journal de médecine de Lyon. Lyon.
Journal of the Medical Association of the State of Alabama. Montgomery.
Journal of the Medical Association of Georgia. Atlanta.
Journal of the Medical Society of New Jersey. Trenton.
Journal of Mental Science. London.
Journal of the Michigan State Medical Society. Lansing.
Journal of National Cancer Institute. Washington, D. C.
Journal of the National Medical Association. New York.
Journal of Nervous and Mental Disease. New York.
Journal of Neurology, Neurosurgery and Psychiatry. London.
Journal of Neuropathology and Experimental Neurology. Baltimore.
Journal of Neurophysiology. Springfield, Ill.
Journal of Neurosurgery. Springfield, Ill.
Journal of Nutrition. Philadelphia.
Journal of Obstetrics and Gynaecology of the British Empire. Manchester.
Journal of the Oklahoma State Medical Association. Oklahoma City.
Journal of Pathology and Bacteriology. Edinburgh.
Journal of Pediatrics. St. Louis.
Journal of Pharmacology and Experimental Therapeutics. Baltimore.
Journal of the Philippine Medical Association. Manila.
Journal of Physiology. Cambridge.
Journal of the South Carolina Medical Association. Florence.
Journal of the Student American Medical Association. Chicago.
Journal of the Tennessee State Medical Association. Nashville.
Journal of Thoracic Surgery. St. Louis.
Journal of Tropical Medicine and Hygiene. London.
Journal of Urology. Baltimore.
Journal-Lancet. Minneapolis.
Klinische Monatsblätter für Augenheilkunde. Stuttgart.
Laboratory Investigation. Philadelphia.
Lancet. London.
Laryngoscope. St. Louis.
Louisiana State Medical Society Journal. New Orleans.
Maandschrift voor kindergeneeskunde. Leyden.
Maryland State Medical Journal. Baltimore.
Medical Annals of the District of Columbia. Washington.
Medical Journal of Australia. Sydney.
Medicina. Buenos Aires.
Medicine. Baltimore.
Mental Hygiene. Albany, N. Y.
Metabolism. New York.
Military Surgeon. Washington, D. C.
Minerva chirurgica. Turin.
Minerva ginecologica. Turin.
Minerva medica. Turin.
Minerva pediatrica. Turin.
Minnesota Medicine. St. Paul.
Missouri Medicine. St. Louis.
Münchener medizinische Wochenschrift. Munich.
Nebraska State Medical Journal. Lincoln.
Nederlandsch tijdschrift voor geneeskunde. Amsterdam.
Neurology. Minneapolis.
New England Journal of Medicine. Boston.
New Jersey Medical Society Journal. Trenton.
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V 15
1953

SUBJECT INDEX

This is an index to all the reading matter in THE JOURNAL. In the Current Medical Literature Department only the articles which have been abstracted are indexed.

The letters used to explain in which department the matter indexed appears are as follows: "BI," Bureau of Investigation; "E," Editorial; "C," Correspondence; "ab," abstracts; the asterisk (*) indicates an original article in THE JOURNAL.

This is a subject index and one should, therefore, look for the subject word, with the following exceptions: "Book Notices," "Deaths," "Medicolegal Abstracts" and "Societies" are indexed under these titles at the end of the letters "B," "D," "M," and "S." Matter pertaining to the Association is indexed under "American Medical Association." The name of the author, in brackets, follows the subject entry.

For the author index see page 1653.

A

ACTH: See Corticotropin
Ak LEUKEMIC EXTRACTS
filtrable agent causing mouse salivary gland carcinoma, 150—E
Au^{198}: See Gold, radioactive
ABDOMEN: See also Ascites; Gastrointestinal Tract; Peritoneum
acute conditions at emergency service, Chilean hospital, 1111
acute conditions in infantile diarrhea, Mexico, 234
emergencies in newborn, [Cooper & others] *1079
retroperitoneal masses, percutaneous femoral artery aortography for, [Peirce] 757—ab
Retropneumoperitoneum: See Retropneumoperitoneum
Surgery; See also Cesarean Section
surgery, liver nodules found at laparotomy, [Mixter] 1049—ab
tumors (retroperitoneal) cause of low back and leg pain, [Anderson] 1052—ab
Viscera: See Viscera
ABNORMALITIES: See also Crippled; Monsters; under specific organ and region as Heart; Lungs
congenital, and excessive vitamin A, 1176—E
in infant after maternal rubella, [Tedeschi] 1483—ab
100 Japanese children exposed in utero to detonation of atomic bomb, 218—E
rubellar embryopathy, [Malbran] 886—ab
Turner's syndrome, (in female), [Jackson] 1217—ab; (in male) [Sougin Mibrohan] 1217—ab
ABORTION
criminal, eight years ago: any residual physical signs? 1232
criminal, potassium permanganate as abortifacient, London, 1301
habitual, caused by wide uterine isthmus, [Swaab] 767—ab
legal, statistics, Sweden, 1569
missed; was patient pregnant? 607
ABSCESS: See also Ulcers; under organs affected
chronic, streptokinase-streptodornase in enzymatic decortication, [Halse] 687—ab
sterile, after immunization, 1067
ABSENTEEISM: See Industrial Health, workers absenteeism
ABSORPTION: See Malabsorption Syndrome
ACADEMIC FREEDOM
in military medical research, [Karsner & Phillips] *1356
ACADEMY: See under name of specific academies as American Academy; list of societies at end of letter S
ACCELERATOR
Linear: See Linear Accelerator
ACCIDENTS: See also Casualties; Disasters; Trauma
A.M.A. exhibit on, 434
among teen-agers, 572
Automobile: See Automobiles
farm, 34—E
fatal; experiences under Ohio coroner's system, [Landé & Boone] *179
fatal; leading causes of death, 1177—E; (Alaska) 1371
firearm, prevention of, 1365—E
home, prevention program by W. K. Kellogg Foundation, Ky., 37
Industrial: See Industrial Accidents
Insurance: See Medicolegal Abstracts at end of letter M
Prevention: See also National Safety Council prevention, courses in, N. Y., 1290
ACE Elastic Hose (for Men), 1285
ACETONE
examination of tissue sections, (replies) [Wright; Pickard] 1328
ACETYLCHOLINE
treatment, injection, combined with epinephrine in atopic dermatitis, [Lobitz] 512—ab
ACHALASIA: See Stomach cardiospasm
ACHYLIA gastrica: See Stomach
ACID
acetylsalicylic, plus p-aminobenzoate in rheumatoid arthritis, [Zarafonetis] 1120—ab
acetylsalicylic, treatment of nonbacterial respiratory infections, [Jones & others] *262
Amino Acids: See Amino Acids
p-aminobenzoic plus acetylsalicylic acid in rheumatoid arthritis, [Zarafonetis] 1120—ab
p-aminosalicylic, and dihydrostreptomycin, effect in artificial pneumothorax [Birath] 1210—ab
p-aminosalicylic, N.N.R., (Sharp & Dohme), 727
p-aminosalicylic, plus streptomycin and thiosemicarbazone in tuberculosis, Turkey, 1471
p-aminosalicylic plus streptomycin in pulmonary tuberculosis, [Medical Research Council] 1059—ab
p-aminosalicylic, plus streptomycin in renal tuberculosis, [Lattimer] 172—ab
p-aminosalicylic, sodium salt, N.N.R., (Chemo Puro; Merck) 727; (Pasmed of Intermedico) 1447
p-aminosalicylic (sodium), thrombocytopenia induced by, [Wurzel & Maycock] *1094
p-aminosalicylic, streptomycin, and isoniazid combined for tuberculosis, Denmark, 1300; [Jensen] 1594—ab
p-aminosalicylic, "swing therapy" in pulmonary tuberculosis, [Tanner] 1407—ab
p-aminosalicylic, used in tuberculosis, streptomycin resistance after, [Turnbull] 251—ab
p-aminosalicylic, vs. 5 other agents used in pulmonary tuberculosis, [Tempel] 589—ab
ascorbic, and adrenal cortex, Italy, 1467
ascorbic, intimal ground substance in atherosclerosis, [Willis] 685—ab
ascorbic, sodium salt, N.N.R., (Vitarine) 925
ascorbic, treatment of anemia, [Spies] *188
ascorbic, 25 mg. neutralized in body by smoking 1 cigarette, 527
ascorbic—U.S.P., N.N.R., (Rexall) 727
ascorbic, vitamin C deficiency, 527
Barbituric: See Barbiturates
Carbolic: See Phenol
Cevitamic: See Acid, ascorbic
folic, and vitamin B_{12} treatment of pernicious anemia, [Spies] *190
folic, excretion test in intestinal malabsorption [Girdwood] 765—ab
folic, liver extract, and vitamin B_{12} in pernicious anemia, [Canelas] 1215—ab
folic, treatment of anemia, [Spies] *188
Folic, Antagonists: See Aminopterin
Hydrochloric: See Stomach acidity
Iodoalphionic (Priodax), orally for cholecystography in infants, [Harris & Caffey] *1333
Iodoalphionic (Priodax), pseudoalbuminuria after [Holoubek & others] *1018
Iodopanoic (Telepaque), orally for cholecystography in infants, [Harris & Caffey] *1333
Iodopanoic (Telepaque), pseudoalbuminuria after [Holoubek & others] *1018
Isonicotinic Hydrazide: See Iproniazid; Isoniazid
nicotinic, treatment of psychiatric syndromes, [Levy] *1260
oxalic, to remove permanganate stains, (replies) [Palmer; Evans] 894
sulfuric, esophagus injury from swallowing, [Dogliotti] 1488—ab
sulfuric, tubercle bacilli isolated after pretreatment with, [Weigand] 71—ab
Uric: See Uric Acid
ACIDITY
Gastric: See Stomach acidity
ACIDOSIS
Diabetic: See Diabetes Mellitus
ACNE: See also Furunculosis
treatment, ultraviolet rays, prolonged use on face harmful? 776
ACROMELALGIA: See Erythromelalgia
ACTH: See Corticotropin
ACTINOMYCES, Antibiotic Prepared from: See Streptomycin
ACTINOMYCOSIS
effect of DDS on Nocardia brasiliensis, Mexico, 446
ACTINOMYCOSIS—Continued
in Scotland, 1568
treatment, aureomycin, [McVay] 59—ab
treatment, isoniazid, [McVay & Sprunt] *95
ACTIVITY: See Exercise
ADAEQUAN: See Blood proteins
ADAMS-Stokes Syndrome: See Heart, block
ADDICTION: See Alcoholism; Barbiturates; Narcotics
ADDISON'S ANEMIA: See Anemia, Pernicious
ADDISON'S DISEASE
kinetic conception [Bastenie] 1226—ab
treatment, long-acting desoxycorticosterone, [Sorkin] 1317—ab
ADDRESSES: See Lectures
ADENITIS: See Lymphatic System
ADENOIDECTOMY
in children, endotracheal anesthesia for, [Pender & Hallberg] *1073
poliomyelitis relation to, [Hayes] 1481—ab
ADENOLIPOMA
of thyroid: new type of goiter, [Chesky] 521—ab
ADENOMA
of lung, [Hutchison] 1583—ab
peripheral and multiple bronchial, [Felton] 60—ab
Nontoxic, of Thyroid: See Goiter
renal, [Childs] 1405—ab
Toxic, of Thyroid: See Goiter, Toxic
ADIPOSITY: See Obesity
ADOLESCENCE
accidents among teen-agers, 572
kyphosis, [Dameron] 250—ab
ADRENALECTOMY: See Adrenals, surgery
ADRENALIN: See Epinephrine
ADRENALS: See also Addison's Disease
Adrenocorticotropic Hormone: See Corticotropin
cortex and ascorbic acid, Italy, 1467
cortex and biology of cortisone, Italy, 1467
Cortex Compound E: See Cortisone
Cortex Hormone (Crystalline): See Desoxycorticosterone
cortex, insufficiency, kinetic conception, [Bastenie] 1226—ab
cortex, interdependence of stress and, in carbohydrate metabolism, [Burns] 979—ab
cortex, pneumographic diagnosis of hyperadrenocorticalism, Italy, 1468
etiologic role in hypertension, [Wilson] 1587—ab
hormone metabolism in paraplegia, [O'Connell & Gardner] *709
Hormone (Sympathetic): See Epinephrine
roentgen study after retropneumoperitoneum, Italy, 1468
surgery, adrenalectomy-sympathectomy combined in essential hypertension, [Zintel] 1403—ab
surgery and sympathectomy in severe hypertension, [Jeffers] 880—ab; [Jeffers & others] *1502
surgery, bilateral adrenalectomy in advanced neoplasms, [Barker] 1319—ab
surgery, bilateral adrenalectomy in Cushing's syndrome, 567—E
surgery, bilateral total adrenalectomy in prostate cancer, [Blunden] 1319—ab
surgery, changes in prostatic cancer after adrenalectomy, [Franks] 1216—ab
surgery, estrogen excretion in breast cancer before and after adrenalectomy, [Dao] 761—ab
surgery for Cushing's syndrome, [Poutasse] 1051—ab
tumors, familial bilateral pheocromocytoma: successful removal in siblings, [Roth] 676—ab
tumors, neuroblastoma of medulla, Turkey, 1471
ADRENOCORTICOTROPIC HORMONE: See Corticotropin
ADVERTISING
food acceptance and, (report) 938
State Journal Advertising Bureau: See American Medical Association

ADVISORY
Board for Medical Specialties, [Kirklin] *349
Commission: See Citizens Advisory Commission
Committee, joint meeting on rural health, 733
Committee on Internships, (Council report) *278; (report) 943
AEROMEDICINE: See Aviation medicine
AERONAUTICS: See Aviation
AEROSOLS
Administration by: See Trypsin
AEROSPORIN: See Polymyxin B Sulfate
AFIBRINOGENEMIA: See Blood
AFRICA
kwashiorkor, (Council article) [Williams] *1280
sanitation programs in, and human factors, 705—ab
AFRICAN VIOLETS
flowering hobby, [Leisure Corner] *55
AFTERBIRTH: See Placenta
AGE
Adolescent: See Adolescence
at time of death in distinguished and undistinguished physicians, [Poynton] 1379—C
breast cancer and, Norway, 663
essential hypertension; prognosis and course, [Palmer & Muench] *1
middle, inguinal hernia in men over 55, [Debenham] 882—ab
myasthenia gravis and, [Schwab & Leland] *1270
Old Age: See Old Age
thyroid cancer prognosis and, [Crile] 679—ab
AGGLUTINATION
of "free-living" endamoeba trophozoites by human serum, Brazil, 47
of Treponema pallidum in syphilitic serums, [McLeod] 761—ab
AGGLUTININS
Rh: See Rh Factor
AGGLUTINOGEN
Rh: See Rh Factor
AGRANULOCYTOSIS
cyclic neutropenia (at 21-day intervals); splenectomy for, [Coventry] *28
etiology: phenylbutazone and 4-amino-antipyrine, [Kiely] 594—ab
immunologic, [Hansen] 67—ab
AGRICULTURE: See Farm
AIR: See also Oxygen
Ambulance: See Ambulances
Compressed: See Caisson Disease
conditioning, relief for hay fever patients, 1066
cysts (pulmonary), [Harden] 62—ab
Dust in, as Industrial Hazard: See Pneumonoconiosis
fresh air therapy in tuberculosis, [Placak] *796
Injection: See Pneumoperitoneum; Pneumothorax, Artificial
pollution, meeting on, Indiana, 569
pollution, research on, Calif., 1556
Presence of Air in Cavity: See Pneumoperitoneum; Pneumothorax
smog, London, 1566
smoke and cancer, London, 1039
spaces (abnormal) in lungs, [Mayer & Rappaport] *700
AIR FORCE: See Aviation, U. S. Air Force
AIR PASSAGES: See Respiratory System
AIRPLANES: See Aviation
β-ALANINE
treatment of malaria, Brazil, 1195
ALBEE Lecture: See Lectures
ALBERT Fellowship: See Fellowships
ALBUMIN
in Blood: See Blood proteins
in Urine: See Albuminuria
ALBUMINURIA
Pseudoalbuminuria: See Pseudoalbuminuria
routine tests for: heating method and non-heating chemical methods compared, 692
ALCOHOL
Addicts: See Alcoholism
amount that can be tolerated, 1414
blood alcohol concentration, (correction) 439
blood alcohol concentrations in relation to drinking wine, [Serianni] 521—ab
coronary vasodilators evaluated, [Russek & others] *207
experimental ethylism, Paris, 663
ingestion aggravate symptoms of hay fever? 1066
Propyl: See Isopropyl Alcohol
ALCOHOLISM: See also "Drunkenness" under Medicolegal Abstracts at end of letter M
A.M.A. Subcommittee on Chemical Tests for Intoxication, (Committee report) 837; 931
Conference on, Miss., 1184
intoxicated motorists and pedestrians, Sweden, 1569
prize for study on, 1559
state services, N. Y. 1456
sulfobromophthalein clearance test, [Goodman & Kingsley] *362
treatment, disulfiram, [Martensen-Larsen] 1484—ab, [Feldman & Zucker] *898
treatment, present-day medical management, [Feldman & Zucker] *895
vomiting in, new antiemetic drug: compound 2061-A, [Friend & Cummins] *480
ALEXANDER, DATE R., operated Kansas City diploma mill, 666—BI
ALIENS: See Physicians, foreign
ALIMENTARY TRACT: See Gastrointestinal Tract
ALKALI
plastic reagent bottles for alkalis [Cornbleet] 1571—C
ALLERGY: See also Asthma; Dermatitis venenata; Eczema; Hay Fever
American Foundation for Allergic Diseases organized, 1105
diagnosis of digestive allergies, Belgium, 1111
experimental arterial, streptococcus toxin-antitoxin in, [Mokychic] 1211—ab
in identical twins, [Bowen] 61—ab
in newborn prevented by withholding cow's milk from diet, [Glaser & Johnstone] *620
reactions after rabies vaccine, [Blatt] 1574—ab
sensitivity to antihistamines; dermatologic preparations omitted from N.N.R. (Council report) 1447
sensitivity to BCG, duration, Finland, 1377
sensitivity to drugs: endangiitis obliterans, [Schmid] 982—ab
sensitivity to Melmac Orthopedic Composition, [Conrad & Ford] *557
sensitivity to new blood factor U, [Wiener & others] *1444
sensitivity to penicillin, fatal shock, [Pick] 1406—ab
sensitivity to penicillin in endocarditis; corrected with antihistamine, [Beck] *1170
sensitivity to penicillin; reactions not prevented by adding antihistamine, 258; (replies) [Rapaport & others; Luippold; Simon; Roberts] 1498
sensitization of skin to antibiotics in medical personnel, London, 583
thrombocytes in allergic processes, [Storck] 1132—ab
treatment, desensitization, all-year-round vs. preseasonal? 1066
vaccinal, discussed by Prof. Salvioli, Italy, 1197
vomiting of pregnancy: allergic factor, [Youssef] 600—ab
N-ALLYLNORMORPHINE Hydrochloride: See Nalorphine Hydrochloride
ALOPECIA
after anticoagulant therapy, [Fischer] 690—ab
areata, 991
ALPHAPRODINE HYDROCHLORIDE (Nisentil) name accepted by Council, 801
ALTITUDE
High: See also Aviation
high, advisable in polycythemia vera? 1415
high, free balloon ascent to 72,395 feet, [LaGorce] 974—C
high, mortality of young rats at mountain heights, Argentina, 162
stress, cardiorespiratory function during, [Marbarger] 1401—ab
ALUMINUM
monostearate, penicillin in oil containing, for early syphilis, [Thomas] 678—ab
ALVARENGA Prize Lecture: See Lectures
AMBUCOPTER: See Ambulances
AMBULANCES
evacuation and care of casualties in hospital plane and helicopter, [White & Merkle] *20
AMEBIASIS
amebic granuloma in large intestine, Brazil, 745
diagnosis; antibiotic therapy, [Weiser] 59—ab
treatment, fumagillin, leukopenia after, [Malewitz] *1446
AMENORRHEA
as patient pregnant? 607
AMERICAN: See also National; Pan American; United States; list of societies at end of letter S
Academy of Pediatrics' manual on hospital care of newborn, [Clifford] *473
Association of Medical Clinics; group practice study, (report) 955
Association of Physicians, report on Jacob S. Schirmer, 665—BI
Board of Anesthesiology, (certification; requirements, examination; fee) *392
Board of Dermatology and Syphilology, (purpose; requirements; examination; certification) *393
Board of Internal Medicine, (requirements; examination; certification) *396
Board of Neurological Surgery, (requirements; reexamination) *400
Board of Obstetrics and Gynecology, (requirements; fees, examination) *401
Board of Ophthalmology, (requirements; examinations) *406
Board of Orthopaedic Surgery, (requirements; examination; certification) *407
Board of Otolaryngology, (requirements; examination; certification) *410
Board of Pathology, (requirements) *412
Board of Pediatrics, (requirements; examinations) *415
Board of Physical Medicine and Rehabilitation (requirements; examinations) *417
Board of Plastic Surgery, (requirements; examinations; certifications; fees) *418
AMERICAN—Continued
Board of Preventive Medicine, (requirements; examination; fees) *421 (authorized to certify candidates in public health and aviation medicine) 944
Board of Proctology, (requirements; examination) *422
Board of Psychiatry and Neurology, (graduate training programs acceptable by) *388; (requirements; examination) *424
Board of Radiology, (certificates; requirements) *425
Board of Surgery, (requirements; examinations; certification) *427
Board of Urology, (requirements; certification; fees) *429
Boards, approved examining boards in medical specialties, [Kirklin] *389; (credit for military service) *390
Cancer Society: See Cancer
Dental Association, chlorophyll and deodorization, 728—E; [Westcott; Ryan; Langley] 749—C; [Hein] 1571—C
Fellowships Offered by American Societies: See Fellowships
Foundation: See Foundations
Hospital Association, (Joint Committee on Hospital-Physician Relationship, President McCormick's page discusses) 433; (letter from, on death of Dr. E. L. Henderson) 733; (opposed to requiring physicians paying hospital percentage of their fees) 829
Indians: See Indians
Legion, A.M.A. resolution on remarks of Commander of, (report) 829
Medical Education Foundation: See Foundations
Medicine: See Medicine
Physicians Art Association, "Sunday" Painter, [Leisure Corner] *508
Prizes Offered by American Societies: See Prizes
Psychiatric Association, (joint conference on mental health with) 931; 1024; (committee to certify mental hospital administrators) 1559
Red Cross: See Red Cross, American
AMERICAN MEDICAL ASSOCIATION
Advisory Committee to Director of Department of Public Relations, (report) 830
American Medical Education Foundation, *111; (funds disbursed to medical schools) 858; (A.M.A. resolution on) 927; (3rd annual report) 956
Annual Congress on Medical Education and Licensure, 927; 945
Annual Medical Public Relations Conference (6th), Nov. 30, 1953, 494; 830; 961; **(program) 1024**
Annual Meetings, schedule for 1954-1956, 1449—E
Annual Reports, October 31, November 7, 1953, pages 829; 926
Archives: See subhead: Journals (special)
Board of Trustees, (annual report) 829
"Bricker Amendment" to U. S. Constitution on making of treaties, 566—E
Bureau of Exhibits, (new exhibits on accidents and immunization) 434; (annual report) 845; (exhibit on pumping action of heart and its valves) 1024
Bureau of Health Education, (annual report) 851
Bureau of Investigation, (Jacob S. Shirmer) 647—E; 665; (annual report) 940; (business of bolstering bosoms: surgical activities of Dr. Robert A. Franklyn) 1200
Bureau of Legal Medicine and Legislation: See also Laws and Legislation, state
Bureau of Legal Medicine and Legislation, (annual report) 837
Bureau of Medical Economic Research, (annual report) 844; (survey of physician attitudes toward voluntary health insurance) 1286—E
Cancer nostrums and quackery exposed by, statement by Dr. Wermer, 731
Chemical Laboratory, (annual report) 937
Citizens Advisory Commission on Medical Care of Dependents of Military Personnel, (President's page) 1178
Clinical Meeting: See also Denver Clinical Meeting; St. Louis Clinical Meeting
Clinical Meeting schedule for 1954-1955, 1449—E
Committee: See also subheads: Joint Committee; Local Committee; Reference Committee
Committee for Study of Nursing Shortage, [Murdock] *1442
Committee in 1942 to study problem of medical examiner and coroner, 1100—E
Committee on Cosmetics, (4th annual report) 936; (Rule Book) 961
Committee on Indigent Care: See subhead: Council on Medical Service
Committee on Legislation, (annual report) 834
Committee on Medical Motion Pictures, (revised catalog) 732; (annual report) 846
Committee on Medicolegal Problems, (annual report) 836
Committee on Mental Health, (1st annual report) 930; (Joint Conference on Mental Health) 931; 1024

V 15
1953

AMERICAN MEDICAL ASSOCIATION—Continued
Committee on Pesticides, (annual report) 932; (new publications) 1182
Committee on Relations between Medicine and Allied Health Agencies, Dr. McCormick's statement, 730
Committee on Research, (William Volker Fund extends grant-in-aid program) 35—E; (Subcommittee on Steroids and Hormones, statement of Dr. Werner) 731; (annual report) 933
Committee on Rural Health: See subhead: Council on Rural Health
Conference on Physicians Placement Service Activities, *1116
Conferences on Veterans Medical Care sponsored by A.M.A. Council, 961
Convention: See subhead: Annual Meetings; San Francisco Meeting
Cooperation: See subhead: Representatives
Cooperative Medical Advertising Bureau: See subhead: State Journal Advertising Bureau
Council on Foods and Nutrition, (trace elements in brucellosis) [Berman] *643; (statement on vitamin D preparations as suitable for use in Council-accepted vitamin D fortified milks) 645; (annual report) 938; (kwashiorkor) [Williams] *1280; (Goldberger award to Dr. McLester) 1367; (withdraws acceptance of SMA concentrated liquid) 939; 1521
Council on Industrial Health, (annual report) 833; (chromate hazards) [Walsh] *1305
Council on Medical Education and Hospitals, (medical education in U. S. and Canada; 53rd annual report) *105; 148—E; (joint survey of medical education) 106; 149—E; (minimum professional requirements) *128; (list of postgraduate and continuation courses) *135; 1365—E; *1381; (approved internships and residencies in U. S., annual report on) *275; 431—E; (list of approved internships) *282; (list of approved residencies and fellowships according to specialties) *311; (annual report) 941; (essentials of acceptable school of medical technology, revised to December 1953) 946; (Dr. Turner appointed secretary) 946; (questionnaire on postgraduate education) 1022—E; (new associate secrtary: Dr. Wiggins) 1367; (standardization of nursing home) [Murdock] *1442; (additional hospitals registered) 1572
Council on Medical Service, (maternity and infant care provision for servicemen's dependents) [Carter & others] *51; (rating communities from physician's standpoint for establishing a practice) 236; (county medical society grievance committees) 494; *510; (placement of physicians in Illinois) 671; (annual report) 947; Committee on Indigent care) 949; (sponsors regional conferences on veterans medical care) 961; (summary of study of multiple screening) *1042; (Conference on Physicians Placement Service Activities) *1116; (survey of physician attitudes toward voluntary health insurance) 1286—E; (placement of physicians in Texas) *1473; (state physician placement activities) 1522—E
Council on National Emergency Medical Service, (annual report) 840; (analysis of doctor-draft regulations) 1201
Council on Pharmacy and Chemistry, (William Volker Fund extends grants-in aid program of Committee on Research) 35—E; (report on use of muscle relaxants) 800; (new generic and brand names recognized by) 801, 1447; (annual report) 932; (changes in consistencies of commercial contraceptives) [Gamble] *1019; (dermatological preparations of antihistamines omitted from N.N.R.) 1447
Council on Physical Medicine and Rehabilitation: See also subhead: Physical Laboratory
Council on Physical Medicine and Rehabilitation, (calculators for applying Ogino-Knaus theory) *32; (Transistor Hearing Aid) 491; (annual report) 937; (intracervical and intrauterine devices) 1285; (Apparatus Accepted) 1367
Council on Rural Health, (scrolls for cofounders of the council; photo) 152; (annual report) 847; (to sponsor Rural Health Conference in Dallas) 858; (conference with farm leaders) 1367
Council on Scientific Assembly, (Bureau of Exhibits cooperates with) 846
Davis (Nathan S.) silver cup presented to, by heirs, 1367
Denver Clinical Meeting, (Bureau report on exhibits) 845
Department of Public Relations, (annual report; 4 objectives) 830
Directory-Biographical Division, (annual report) 830
AMERICAN MEDICAL ASSOCIATION—Continued
Dues: See subhead: Membership dues
"equalization pay" for physicians in armed forces, 646—E
Exhibits: See also subheads Scientific Exhibit; Technical Exposition
exhibits of the Association (Bureau annual report) 846
Film Library: See subhead Motion Picture
Fund for Medical Education: See subhead: American Medical Education Foundation
General Practitioners' Award to Dr. Greenwell, 1366—E; 1526
grants for research, list of, 934
House of Delegates, St. Louis Clinical Meeting, 806; (list of reference committees with membership) 806; (list of delegates) 807; (report on matters referred by) 829; (directives of) 927; (apportionment of delegates affected by uniformity in membership regulations) [Cargill & Tracy] *1179; **(proceedings) 1526**
Hygeia: See subhead: *Today's Health*
Joint Committee on Hospital-Physician Relationships, President's page, 433
JOURNAL, (subscription and circulation) 927; (annual report) 928
journals (special), (subscription and circulation) 927; (annual report) 928
Laboratories, (annual report) 937
Library, (annual report) 929
Local Committee on Arrangements, St. Louis Clinical Meeting, Dec. 1-4, 805
McCormick (Edward J.) statement before U. S. House Committee, (on retirement funds for self-employed persons) 151; (on medical research and progress) 730; (address before House of Delegates) *1529
MEDICOLEGAL ABSTRACTS, 838
meetings, schedule for 1954-1956, 1449—E
Membership, (annual report) 826; (development of uniformity in regulations between constituent associations and A.M.A.) [Cargill & Tracy] *1179
Membership dues, (resolution on payment of back dues) 927; (delinquency dates in payment of; collection; confusion over exemption policies) [Cargill & Tracy] *1179
Microbiologic Laboratory Section, (annual report) 937
Motion Pictures: See also subhead: Committee on Medical Motion Pictures
Motion Pictures Film Library, new film added to, 1308
Motion Pictures, List of Pictures Reviewed: See Moving Pictures, Medical
National Conference on Physicians and Schools, 151; 853; 858
National Education Campaign terminated, 830
National Fund for Medical Education *111; 942
New and Nonofficial Remedies, dermatological preparation of accepted antihistamine omitted from, 1447
New York Annual Meeting, (exhibit) 846
Officers, (list of, for 1953-1954) 803; (reports) 829; 926
Official Call to Officers and Members, 803
Physical Laboratory, (annual report) 938
placement service, *1116
policy, Dr. K. B. Castleton speaks his mind on, A. M. A. Secretary's letter, 151
President's Page, (monthly message) (Sept.) 433; (Oct.) 857; (Nov.) 1178; (Dec.) 1525
Press Relations, (annual report) 830
Proceedings of the St. Louis Clinical Meeting, 1526
Program for St. Louis Clinical Meeting, 808
Public Relations, (manual: Rx PR) 434; (Department of Public Relations, 4 objectives, annual report) 830; (Conference) 494; 830; 961; **(program of conference) 1024**
publications, (recent) 152; 732; 961; 1182; 1367
QUARTERLY CUMULATIVE INDEX MEDICUS, (annual report) 929
Reference Committees, (list of, with membership, 806; 1528
Reports of Officers, October 31, November 7, 1953, pages 829; 926
representatives to various meetings increasing, 829
resolution on American Medical Education Foundation, 927
resolution on compact of western states for higher education, 829
resolution on derogatory article in May, 1953, issue of "Home Life," 829
resolution on executive order of President of U. S., 927
resolution on expression of appreciation to physicians of Korea, 927
resolution on payment of back dues, 927
resolution on portrayal of physicians in television and radio advertising, 829
resolution on remarks of commander of American Legion, 829
resolutions to be introduced at St. Louis Meeting, 927
Reuling (James R.), address by, *1527
AMERICAN MEDICAL ASSOCIATION—Continued
St. Louis Clinical Meeting, (advance registration) 152; (arrangements being completed for) 434; 494; (official call to) **803;** 855—E; (Scientific program) 808, (medical color television—story of progress) 1100—E; (editorial review) 1448—E; (pictures) 1452; 1453 **(proceedings) 1526**
San Francisco Meeting, (report) 830; (Scientific Exhibit) 961; 1367
Scientific Exhibit, (at St. Louis Clinical Meeting, Dec. 1-4, 1953) 814; (Bureau annual report) 845; (San Francisco Annual Meeting) 961; 1367
Scientific Program, St. Louis Clinical Meeting, Dec. 1-4, 808
Secretary, (annual report) 926
Secretary's letter: Dr. K. B. Castleton speaks his mind on A.M.A. policy, 151
Section on Dermatology and Syphilology, (chairman's address) [Lamb] *1509
Section on Diseases of the Chest, (chairman's address) [Placak] *795
Section on Experimental Medicine and Therapeutics, Symposium on Recent Advances in Nephritis, [Corcoran] *1233; [Luetscher & others] *1236; [Keith & Odell] *1240; [Goldring] *1245; (chairman's address), [Seevers] *1329
Section on General Practice, (chairman's address), [Mills] *910
Section on Hospital Service and Technical Schools, activities, (annual report) 944
Section on Military Medicine, (chairman's address) [Kern] *457
Section on Nervous and Mental Diseases, (chairman's address), [Forster] *609
Section on Ophthalmology, (chairman's address) [Adler] *1358; 1365-E
Section on Orthopedic Surgery, (chairman's address), [McCarroll] *536
Section on Pediatrics, (chairman's address), [McKenry] *627
Section on Pediatrics, Symposium on Prevention of Needless Neonatal Deaths, [Bundesen] *466; [Clifford] *473; [Letourneau] *476
Section on Preventive and Industrial Medicine and Public Health, (chairman's address) [Getting] *265
Section on Radiology, (chairman's address), [Hodges] *1417; (Symposium on Roentgen Examination of Gastrointestinal Tract) [Hodges] *1417; [Swenson] & Jeffrey] *1422; [Sommer & Goodrich] *1424; [Giantureo & Miller] *1429; [Golden & Morales] 1431
Section on Surgery, General and Abdominal, (chairman's address), [Trimble] *1143
Section on Urology, Symposium on Fertility, [O'Conor] *532; [Bishop] *534; Symposium on Neurogenic Bladder, [Thompson] *1337; [Powell] *1341; [Van Duzen & Duncan] *1345
Sections delegates from, St. Louis Clinical Meeting, Dec. 1-4, 808
STANDARD NOMENCLATURE OF DISEASES AND OPERATIONS, (annual report) 929
State Journal Advertising Bureau, (annual report; list of 34 states having membership in) 849
State Medical Journal Conference, 434
Student A.M.A. (annual report) 957
Subcommittee on Alcoholism, (report) 931
Subcommittee on Grants-in-Aid, (list of research grants given by) 934
Symposium: See subheads: Section on Experimental Medicine; Section on Pediatrics; Section on Radiology; Section on Urology
Technical Exposition, St. Louis Clinical Meeting, 822
television, (new films) 434; (series: "March of Medicine") 494; (program at St. Louis Clinical Meeting) 813; (cancer research theme of second telecast) 858
Today's Health, (annual report), 849; (win awards) 1367
Trustees: See subhead: Board of Trustees
Washington Office, (annual report) 842
Washington Office, Summary of Federal Legislation: See Laws and Legislation, federal
Wermer (Paul) statement on cancer diagnosis, treatment and research before U. S. House Committee on, 731
Whitaker and Baxter Advertising Campaign: See subhead: National Education Campaign
Woman's Auxiliary: See Woman's Auxiliary
AMIDOPYRINE: See Aminopyrine
AMINO ACIDS
malaria and, Brazil, 1195
utilization, effects of mineral deficiencies, [Frost] 174—ab
AMINO-ANTIPYRINE
toxicity: agranulocytosis, [Kiely] 594—ab
o-AMINOAZOTOLUENE
tumors in dogs fed with, [Nelson] 170—ab

p-AMINOBENZOIC ACID: See Acid
AMINOPHYLLINE
coronary vasodilators evaluated [Russek & others] *207
treatment, intravenous, in incipient apoplexy, [Mainzer] 1405—ab
AMINOPTERIN
treatment of acute leukemia in children, [Kåss] 1224—ab
AMINOPYRINE
treatment of rheumatic disease, [Ballabio] 1191—ab
p-AMINOSALICYLIC ACID: See Acid
AMITHIOZONE (Conteben; Myvizone; TB: Tibione)—Tibione
treatment of pulmonary tuberculosis compared with 5 other agents, [Tempel] 589—ab
treatment plus streptomycin and PAS in tuberculosis, Turkey, 1471
AMMONIA
in renal insufficiency and gout, [Bollinger] 1582—ab
AMMONIUM COMPOUNDS
chloride, melamine resin (Melmac 405), allergic contact dermatitis [Conrad & Ford] *557
Tetraethyl— : See Tetraethylammonium Chloride
AMNION
effect of artificial rupture after arrest of progress in labor, [McCain & others] *695
AMNIOTIC FLUID
fibrinolytic and anticoagulant action, [Vecchietti] 1584—ab
pulmonary embolism, [Bacala] 246—ab
AMPHETAMINE
sulfate—U. S. P., N. N. R., (Smith, Kline) 1363
AMPULS
use color indicator in storing, for spinal anesthesia, [Lewis] 50—C
AMPUTATION
amputee children clinic, N. J., 736
AMUSEMENTS: See Leisure; Physicians, avocations
AMYLOIDOSIS
primary, with gastric involvement, [Cooley] 1122—ab
ANALGESIA: See Anesthesia
ANAPHYLAXIS: See Allergy
ANASTOMOSIS: See Arteries, coronary; Portal Vein
ANATOMY
Morbid: See Pathology
ANATUBERCULIN, Petragnani's: See Tuberculosis, immunization
ANDERS Lecture: See Lectures
ANDROGENS
testosterone for older men, 1598
treatment in gynecology, Italy, 1468
treatment combined with estrogens, Italy, 1468
ANEMIA: See also Anemia, Pernicious
aplastic, fatal, after prolonged use of chloramphenicol, [Koster] 888—ab
aplastic, fatal, after quinacrine [Parmer & Sawitsky] *1172
cardiorespiratory function during altitude stress, [Marbarger] 1401—ab
etiology: copper and iron deficiency in dogs, [Van Wyk] 882—ab
hemolytic (acquired), corticotropin and cortisone for, [Letman] 1593—ab
hemolytic congenital, in Negro brothers, [Irby] *103
hyperchromic, progress in treatment, medicosurgical society discusses, Italy, 1037
hypochromic, iron therapy, Italy, 1037
hypochromic microcytic, severe, from pica, [van Wisselingh] 69—ab
in bacterial endocarditis, [Parsons & others] *14
in liver cirrhosis, Chile, 1036
in paraplegia, [O'Connell & Gardner] *710
in rheumatoid arthritis, [Jeffrey] 241—ab
leuko-erythroblastic, [Beattie] 1217—ab
megaloblastic, of pregnancy, [Piozzi] 1324—ab
megaloblastic, serum vitamin B_{12} concentration in, [Mollin] 1485—ab
normochromic, progress in treatment, medicosurgical society discusses, Italy, 1037
nutritional macrocytic, vitamin B_{12} in, [Das Gupta] 1486—ab
ovalocytosis, (reply) [Lipton] 776
pancytopenia in occult subacute bacterial endocarditis [Parsons] 881—ab
Splenic (Banti's Disease): See Splenomegaly
treatment, ascorbic acid, folic acid, and vitamin B_{12}, [Spies] *188
treatment, difficulty in treating simple type, (reply) [Stetson] 608
ANEMIA PERNICIOUS
treatment, liver extract, folic acid, and vitamin B_{12}, [Canelas] 1215—ab
treatment vitamin B_{12} and folic acid, [Spies] *190
treatment, vitamin B_{12}, massive dosage, [Lerebollet] 601—ab
ANEMIA, PERNICIOUS—Continued
treatment, vitamin B_{12} with intrinsic factor concentrate, N.N.R., (description) 565; (Organon) 565
ANESTHESIA
choice of, in cardiac disease, 786—ab
combined with curare in cesarean section, [Bergquist] 1129—ab
efocaine, death after using, [Angerer & others] *550
endotracheal, for tonsillectomy and adenoidectomy in children, [Pender & Hallberg] *1073
endotracheal, instrument for, during oropharyngeal surgery, [Barton] *1017; (correction) 1460
explosions, conductive flooring for operating rooms to guard against, 608
hypotensive, [Brunschwig] 1056—ab
hypotensive, in plastic surgery, [Bentel] 601—ab
International Anesthesia Research Society, 157
intravenous, for obstetrical delivery, [Rucker] 1311—ab
muscle relaxants used in, (Council report), 800
Narcosis (prolonged): See Narcosis
paravertebral block with aqueous phenol, [Haxton] 167—ab
spinal, relation to poliomyelitis, 527
spinal, storing ampuls for: use of color indicator, [Lewis] 50—C
trichlorethylene, 693; (replies) [Davis; Wilcox] 1416
ANESTHESIOLOGY
American Board of: See American Board
American Society of Anesthesiologists, meet in Seattle, 499
assembly in, N. Y., 1290
ANEURYSM
aortic (abdominal), surgical resection and continuity restored with homograft, [DeBakey] 1214—ab; 1523—E
aortic, excisional therapy, [DeBakey] 880—ab
aortic, rupture into esophagus, gastrointestinal hemorrhage from, [Calenda & Uricchio] *518 [Baer] 1571—C
aortic (syphilitic thoracic), rupture in stomach, [Renner & Sindelar] *102
arteriovenous (congenital pulmonary), [Sloan] 1047—ab
cirsoid and arteriovenous, of brain, [Petit-Dutaillis] 888—ab
intracranial, associated with polycystic kidneys, [Bigelow] 58—ab
intracranial, subarachnoid hemorrhage from rupture; surgery for, [Dowling] 1407—ab
of cholecystic artery, [Schaefer] 1114—C
of circle of Willis, treatment, [Norlén] 758—ab
ANGER
edema of unknown origin, (reply) [Jonas] 1068
ANGINA
Agranulocytic: See Agranulocytosis
Monocytic: See Mononucleosis, Infectious
ANGINA PECTORIS
cardiorespiratory function during altitude stress, [Marbarger] 1401—ab
incidence relation to body weight, [Master & others] *1500
like pains, 1328
treatment, coronary dilators, reappraisal, [Silber & Katz] *1075
treatment, ethaverine; daily report cards employed [Voyles & others] *12
treatment, heparin, [Donzelot] 254—ab
treatment, vasodilator drugs, electrocardiographic tests to evaluate effects, [Russek & others] *207
ANGIOGRAPHY: See Blood Vessels, roentgen study
ANGIOLOGY: See Blood Vessels
ANGIOMA: See Hemangioma
ANGIOSPASM: See Raynaud's Disease
ANILINE
dye, dangers of marking-ink, London, 875
ANIMAL EXPERIMENTATION
aid to antivivisectionists, London, 1039
ANIMALS: See also Veterinarians; and under specific names as Cats; Cattle; Dogs
Experimentation on: See Animal Experimentation
feed, dairy ration supplemented with trace elements to prevent brucellosis (Council article), [Berman] *643
ANITSCHKOW'S CELLS
in rheumatic granuloma, [von Albertini] 1491—ab
ANKLE
Charcot's joints, 991
ANKYLOSIS
of temporomandibular joint, diplopia after, 1231
ANNUAL Conference: See American Medical Association
Congress: See American Medical Association
ANOMALIES: See Abnormalities; under names of specific organs as Heart
ANOXIA: See Oxygen deficiency
ANTABUSE: See Disulfiram
ANTAZOLINE (Antistine)
effect on coagulation time, 1229
treatment plus desoxycorticosterone for vomiting in pregnancy; allergic factor, [Youssef] 600—ab
ANTHRACOSILICOSIS: See Pneumonoconiosis
ANTHRAX
bacillus: sensitivity to antibiotics, [Boger] 512—ab
ANTIBIOTICS: See also Bacitracin; Chlortetracycline (Aureomycin); Chloramphenicol; Erythromycin; Neomycin; Oxytetracycline (Terramycin); Penicillin; Streptomycin
Commercial Solvents Award, 156
medicine, warfare, and history, [Fulton] *182
medico-surgical meeting discusses, Chile, 1565
sensitivity to: Bacillus anthracis, [Boger] 512—ab
sensitivity to: Shigella, [Felsen & Wolarsky] *1071
skin sensitization to in medical personnel, London, 583
synergism and antagonism of, [Meleney & Johnson] *1259
treatment, affect rising antibody titer in typhus? 775
treatment, failure in infectious mononucleosis, [Walker] 587—ab
treatment of ameblasts, [Welser] 59—ab
treatment of multiple bone lesions in Letterer-Siwe disease, [Fisher] 62—ab
treatment of nephrotic state, [Luetscher & others] *1256
treatment of nonbacterial respiratory infections, [Jones & others] *262
treatment plus corticotropin and cortisone in in overwhelming infections, [Kinsell] 684—ab
treatment, staphylococcic gastroenterocolitis after, [Terplan] 1481—ab
treatment to control surgical infections, [Meleney & Johnson] *1253
treatment vs. sulfonamides in bacillary dysentery, [Felsen & Wolarsky] *1071; [Cheever] 1199—C
treatment vs. surgery in otitis media, [McLaurin] 683—ab
ANTIBODIES
Rh: See Rh Factor
titer in typhus, what is effect of antibiotic treatment on? 775
ANTICHOLINERGIC DRUGS
treatment of peptic ulcer, [Ruffin & others] *1159
ANTICHOLINESTERASE
octamethyl pyrophosphoramide in myasthenia gravis, [Grob] *531
poisoning from, [Moseley] 1318—ab
ANTICOAGULANTS: See also Bishydroxycoumarin; Heparin
action of amniotic fluid, [Vecchietti] 1591—ab
study of, especially proconvertin and convertin, Norway, 662
treatment compared: bishydroxycoumarin (dicumarol) and PID, Norway, 876
treatment, controlled by Owren's method, in thromboembolic diseases, [Lund] 602—ab; 662; 876
treatment, hemorrhage during, [MacMillan] 1584—ab
treatment, loss of hair after, [Fischer] 690—ab
treatment of coronary thrombosis, Paris, 876
treatment of myocardial infarction, [Schnur] 168—ab; [Furman] 239—ab; [Green] 1404—ab
ANTIGENS: See also Antibodies
Rh: See Rh Factor
variations of Salmonella typhosa, Paris, 664
ANTIHEMOPHILIC PLASMA (human)
N. N. R., (description) 1174; (Hyland) 1174
ANTIHISTAMINES: See also under specific names
dermatologic preparations omitted from N. N. R., 1447
effect on coagulation time; use in pregnancy and profuse menses, 1229
penicillin combined with, in endocarditis, [Beck] *1170
penicillin reactions not prevented by adding, 258; (replies) [Rapaport & others; Luippold; Simon; Roberts] 1498
personality changes in children caused by, [Schaffer] 589—ab
synthetic, in post-transfusion reactions, [Catalano] 1488—ab
treatment plus disulfiram in alcoholism, [Martensen-Larsen] 1484—ab
ANTI-LEWISITE, British: See Dimercaprol
ANTISEPSIS: See also Sterilization, Bacterial intestinal, in surgery, [Poth] *1516
ANTISPASMODICS
compound 08959, treatment of paralysis agitans, [Magee & DeJong] *715
ANTISTINE: See Antazoline
ANTITOXIN: See Tetanus
ANTIVIVISECTION: See Animal Experimentation
ANTROSTOMY
nasal, done routinely in children? 456

V 15
1953

ANUS: See also Rectum
fissure (recurrent), [Kratzer] *1165
hemorrhage into hypertrophied papilla cause of rectal pain, [Hayes & Burr] 1115—C
ANXIETY: See Stress
AORTA
Aneurysm of: See Aneurysm
Arteriosclerosis: See Arteriosclerosis
coarctation, surgical treatment, [Sealy] 1214—ab
ectopic stenosis, [Patel] 175—ab
overriding, diagnosis of, [Gordon] 976—ab
roentgen study in arterial emboli, [Lovingood] 1205—ab
roentgen study, percutaneous femoral artery aortography in retroperitoneal masses, [Peirce] 757—ab
surgery, resect acquired coarctation and graft replacement, [Deterling] 1315—ab
surgery: resection with homografts, (in arteriosclerosis), [Julian] 1208—ab; (in aneurysm) [DeBakey] 1214—ab; 1523—E
transposition, [Lillehei] 1402—ab
AORTIC VALVE
rupture, disappearing diastolic pressure as diagnostic sign, [Bean & Schmidt] *214
stenosis, multivalvular disease; simultaneous surgical correction, [Bolton] 756—ab
stenosis, surgical treatment, International College discuss, Italy, 582
surgery: commissurotomy, [Larzelere] 758—ab
syphilitic, insufficiency, natural course, Webster] 513—ab
systolic heart murmurs heard over, [White] 57—ab
AORTOGRAPHY: See Aorta, roentgen study
APOPLEXY: See Brain hemorrhage
APPARATUS: See also Diathermy; Hearing Aids; Instruments
Apparatus Accepted (1953) by A.M.A. Council on Physical Therapy, 1367
barium enema, for roentgen examination of colon, [Hodges] *1420
corrective brace for upper extremity in hemiplegia, [Rudin & others] *479
coupling device for polyethylene catheter, [Alman & Whorlskey] *562
device for objective auscultation of heart, [Briskier] 238—ab
device for tracheobronchial aspiration, [Emerson] *920
intracervical and intrauterine devices, (Council report) 1285
treadmill ergometer to study effect of heparin in intermittent claudication, [Simon & Wright] *98; [Collens] 1115—C; (reply) [Simon & Wright] 1115
APPENDICITIS
perforating, oxytetracycline in, [Schultz] 1489—ab
APPLE SAUCE
Matchless Brand Dietetic Pack, 217
APRESOLINE: See Hydralazine
ARACHNIDISM: See Spiders, bites from
ARACHNOID
ureterostomy to divert spinal fluid in hydrocephalus, [Matson] 1483—ab
ARACHNOIDITIS
intracranial, fatal reaction to ethyl iodophenylundecylate, [Erickson & van Baaren] *636
ARCHIVES of A. M. A.: See American Medical Association, journals, (special)
ARGENTINE
Congress of Gastroenterology, second, 162
ARKANSAS
Warren's report on fraudulent license issued to Jacob S. Schirmer, 647—E; 665—BI
ARM: See Arms
ARMED FORCES: See also Army; Aviation, U. S. Air Force; Korean War; Navy; World War II
Assistant Secretary of Defense for Health Affairs, (Council report) 840
Dependents of Servicemen: See Servicemen
Institute of Pathology (new), (photo), 504
medical officers, surplus, 34—E
physicians for, 432—E; 1022—E
physicians in, "equalization pay" for, 646—E; 841
physicians utilized by, (Council report), 840
sarcoidosis in, [Nelson] 753—ab
U. S. Dept. of Defense, military requirement for physicians, 1022—E
ARMS: See also Elbow; Fingers; Hand; Shoulder; Wrist
Amputation: See Amputation
corrective brace for, in hemiplegia, [Rudin & others] *479
ARMY, UNITED STATES: See also Armed Forces; World War II
atomic scientist (Dr. Fishler) enters, 744
Bayne-Jones (Stanhope) receives "supergrade" in medical service, 1035
Denit (General) retires, 659
Hospitals: See Hospitals
influenza vaccination by, 1194
Legion of Merit awarded, 1298
medical officers receive awards, 1194
physicians (regular) may now resign, 161
Seeley (General) honored, 46
ARRHENOMIMETIC Phenomenon: See Virilism
ARRHYTHMIA: See also Atrial Fibrillation; Atrial Flutter; Ventricular Fibrillation
cardiac, effect of procaine amide, [Boyadjian] 1126—ab
extrasystoles; suppression with digitalis, (reply) [Abraham] 894
ARSENIC
poisoning (chronic), heart disease in, [Robbins] 1316—ab
treatment, hazard of poisoning in psoriatic arthritis, 1230
ARSPHENAMINE
Treatment: See Neurosyphilis
ART: See also Physicians, avocations
medical illustrators meet in Baltimore, 223
"Sunday" painter, [Leisure Corner] *508
ARTANE: See Trihexyphenidyl Hydrochloride
ARTERENOL (Nor-Epinephrine)
treatment in Waterhouse-Friederichsen syndrome, [Weiner] 973—C; [Uhl] 1052—ab
treatment of shock, [Skelton] 595—ab; [Moyer] 1311—ab
l-ARTERENOL: See Levarterenol
ARTERIES: See also Aorta; Blood Vessels; Ductus Arteriosus; Veins
Aneurysm: See Aneurysm
carotid (internal), hearing pulse in the ear, 990
carotid, ligation in middle meningeal hemorrhage, [Raney & others] *1434
cholecystic, aneurysm of, [Schaefer] 1114—C
Coronary: See also Angina Pectoris
coronary dilators and angina, [Silber & Katz] *1075
coronary disease among soldiers, [Sigler] 664—C
coronary disease, electrocardiogram nonspecific in, [Levine] 1321—ab
coronary disease, epinephrine treatment of asthma advisable? 1496
coronary disease, panel on, N. Y., 496
coronary disease, relation to obesity, [Master & others] *1499
coronary disease, surgical treatment: Beck operations, 1496
coronary, internal mammary anastomosis, [Vineberg] 238—ab
Coronary, Occlusion: See also Thrombosis, coronary
coronary occlusion and hypertension, [Master] 1122—ab
coronary occlusion, cause of death in physicians, [Poynton] 1379—ab
coronary occlusion, morphology; pathogenesis, [Papacharalampous] 1591—ab
coronary, occlusion, in coronary embolism, [Cheng & others] *211
coronary patients, nasal medication in, 178
coronary vasodilators, choice of, in clinical practice, [Russek & others] *207
disease (peripheral), value of exercise in; radiosodium clearance to determine muscle blood flow, [Wisham & others] *10
Embolism: See Embolism
extracts in arteriosclerosis, [Schiavetti] 68—ab
femoral, percutaneous aortography to evaluate retroperitoneal masses, [Peirce] 757—ab
hepatic, ligate for portal hypertension, [Popper & others] *1095
Inflammation: See Arteritis; Periarteritis
meningeal (middle), suspected hemorrhage from, [Raney & others] *1434
Pressure in: See Blood Pressure
Pulmonary: See also Embolism, pulmonary
pulmonary, transposition, [Lillehei] 1402—ab
Sclerosis: See Arteriosclerosis
sensitization, streptococcus toxin-antitoxin in, [Mokychic] 1211—ab
walls of, terminal nerve corpuscles in, Italy, 1038
ARTERIOSCLEROSIS
aortic atherosclerosis, role of mucopolysaccharides in, [Taylor] 1479—ab
atherosclerosis, hypercholesterolemia, and myxedema, [Blumgart] 239—ab
atherosclerosis, intimal ground substance in, [Willis] 685—ab
cause of death in physicians, [Poynton] 1379—C
sclerotherapy for varicose veins contraindicated in? 1141
treatment, arterial extract, [Schiavetti] 68—ab
treatment of aged in state mental hospital, [Levy] *1260
treatment, resect aortic bifurcation and use homografts, [Julian] 1208—ab
ARTERITIS: See also Periarteritis
of lower limbs, heparin treatment, [Remy] 1130—ab
ARTHRITIS: See also Gout; Rheumatism
Atrophic or Chronic: See Arthritis, Rheumatoid *following*
basic research, fellowships by Arthritis and Rheumatism Foundation, 39
Degenerative; Hypertrophic: See Joints, degenerative joint disease
lecture on, Mich., 1289
meeting on, N. Y., 1026
National Institute of, Dr. Daft succeeds Dr. Wilder, 744
Neuropathic: See Charcot's Joints
ARTHRITIS—Continued
psoriatic: potassium arsenite (Fowler's solution) for, also Goeckerman treatment, 1230
Spinal: See Spine
treatment, cortisone, International symposium discusses, Italy, 1467
treatment, hydrocortisone (compound F) by local injection, [Ramsey] 759—ab
treatment, prostigmin for muscle spasm, [Howell] 1583—ab
tuberculous, synovectomy and curettage, [Wilkinson] 1220—ab
ARTHRITIS, RHEUMATOID
juvenile, endogenous uveitis in, [Davis] 1574—ab
juvenile (Still's disease), 693
lecture on, N. Y., 736
treatment, *p*-aminobenzoate plus acetylsalicylic acid, [Zarafonetis] 1120—ab
treatment, corticosterone, effects, [Clark] 979—ab
treatment, cortisone, caution advised, London, 1301
treatment, cortisone, perforated gastric ulcer during, [Kerdasha] 1053—ab
treatment, dietetic nutrients before and after cortisone, [Spies] *192
treatment, hydrocortisone [Rubens-Duval] 888—ab
treatment, phenylbutazone and 4-amino-antipyrine, causes agranulocytosis, [Kiely] 594—ab
treatment, phenylbutazone, toxic effects, [Nassim] 524—ab
ARTHRODESIS
compression, of knee, using double wire and tightening lever, [Greifensteiner] 603—ab
ARTHROPATHY, Charcot's: See Charcot's Joints
ARTHROPLASTY
of hip joint, indications, technique, prognosis, [Westerborn] 175—ab
ARTHROPODS
as hosts: causal agent of Q fever (Rickettsia burneti), [Gremliza] 771—ab
ARTIFICIAL
Hibernation: See Narcosis
Insemination: See Impregnation, Artificial
Kidneys: See Kidneys
Pneumoperitoneum: See Pneumoperitoneum, Pneumothorax: See Pneumothorax, Artificial
Respiration: See Respiration
ASCHEIM-ZONDEK TEST
what conditions other than pregnancy will cause positive result? 1229
ASCHOFF BODIES
in auricular appendages in mitral stenosis, [Decker] 1122—ab; [McNeely] 1209—ab
in rheumatic granuloma, [von Albertini] 1491—ab
ASCITES
radioactive gold treatment of malignant effusions, [Seaman & others] *630
ASCORBIC ACID: See Acid, ascorbic
ASPHYXIA
fetal, and its treatment, [Holtz] 767—ab
Local: See Raynaud's Disease
ASPIRATION
tracheobronchial, simple device for, [Emerson] *920
ASPIRIN: See Acid, acetylsalicylic
ASSOCIATION: See also American Medical Association; Societies, Medical; list of Societies at end of letter S
of American Medical Colleges, (survey of medical education by A.M.A. and) *106; 149—E; (number of applicants to medical schools in U. S. compiled by) *123; *129; (first teaching institute of) 652; 1023—E; (broadened its membership) 1291
of Spanish Physicians organized contest for writers and artists, 748
ASTHENIA
Pseudobulbar: See Myasthenia Gravis
ASTHMA
after-cough fainting in, [Derbes] 762—ab
complications: bronchiectasis, Sweden, 49
etiology: hay fever, 1066
etiology: odors of paint, 258
in children, long-acting corticotropin (ACTH) for, Sweden, 584; [Bergstrand] 767—ab
in guinea pigs, effect of stress factors, [Feinberg] 682—ab
ragweed, corticotropin or cortisone for, 1066
silicosis and, 1327
treatment, epinephrine, advisable in cardiovascular disease? 1496
treatment, pancreas extract, [Santenoise] 253—ab
ATABRINE: See Quinacrine
ATAXIA
Friedreich's, 74
Locomotor: See Tabes Dorsalis
ATELECTASIS: See Lungs, collapse
ATHEROSCLEROSIS: See Arteriosclerosis
ATHLETICS: See also Exercise
athletes with defective vision: eligibility of high school boys for contact sports, 892
baseball "pitcher's elbow," 74
fatalities attributed to boxing, 455
gymnasium floors and walls: wooden vs. concrete floors, 893

ATLAS
occipitalization, [McRae] 588—ab
ATMOSPHERE: See Air
"ATOM SMASHING": See Cyclotron
ATOMIC ENERGY: See also Radioactive Isotopes
bomb, abnormalities in 100 Japanese children exposed in utero to detonation of, 218—E
bomb attack, civil defense director looks at the medical problems, [More] *1007
bomb casualties of Nagasaki, [Shirabe] 1482—ab
bombardment, cerebral injuries from, [Uchimura] 171—ab
scientist (Dr. M. C. Fishler) enters U. S. Army, 744
symposium on, Utah, 437
traveling shows, 1458
U. S. Atomic Energy Commission, (radiation protection comes of age) [Chamberlain] *488; (fellowships in industrial medicine), 1298
ATOPIC DISEASE: See Allergy
ATRIAL FIBRILLATION
chronic, use of quinidine in, [Fleischmann] 514—ab
hyperactive carotid sinus reflex of cardioinhibitory type, [Soloff] 1205—ab
ATRIAL FLUTTER
spontaneous, observed during cardiac surgery with color cinematographs and electrocardiograms, [Prinzmetal & others] *553
ATRIOSEPTOPEXY: See Heart surgery
"ATRIUM"
term to replace "auricle," [Hyman] 1304—C
ATROPHY
Muscular: See also Dystrophy, muscular
muscular (progressive neuropathic peroneal), Charcot-Marie-Tooth type, [Brodal] 675—ab
"AURICLE"
term "atrium" to replace, [Hyman] 1304—C
AURICULAR FIBRILLATION: See Atrial Fibrillation
AURICULAR FLUTTER: See Atrial Flutter
AUDIOLOGY: See Hearing
AUDIOVISUAL AIDS: See Moving Pictures: Television
AUREOMYCIN: See Chlortetracycline
AUROTHERAPY: See Gold, radioactive
AUSCULTATION
objective, of heart, new device for, [Briskier] 238—ab
AUSTRALIA
Commonwealth medical benefits scheme, 231
AUTHORSHIP: See Writers
AUTOMOBILES: See also "Motor Vehicles" under Medicolegal Abstracts at end of letter M
accidents, exhibit symposium on prevention, St. Louis Clinical meeting, 494
accidents, intoxicated motorists and pedestrians, Sweden, 1569
accidents, whiplash injuries of neck, [Schaefer] 974—C
accidents, White House conference on highway safety, 1466
bus and truck drivers, difference in calf circumference as guide to thrombophlebitis, [Damon & McFarland] *622
AUTOPSIES
medicolegal experiences under Ohio coroner's system, [Landé & Boone] *179
rates, compared in coroner and medical examiner jurisdictions, [Turkel] *1087
rates (highest), internship hospitals with, 1952-1953, (Council report) *279
AUXILIARY: See Medical Auxiliaries; Woman's Auxiliary
AVIATION: See also Altitude, high
Aero Medical Meeting, 225
airplane travel and diseases of lungs, 1435—ab
evacuation and care of casualties in hospital plane or helicopter, [White & Merkle] *20
gastrointestinal disorders and flying, 643—ab
medicine, advances in, [Fulton] *482
medicine, careers in, 46
medicine (naval), course in, 46
AVIATION, U. S. AIR FORCE
flight surgeons needed, Conn., 1556
French medals awarded, 46
medical officer (Major Lifton) receives award, 1466
preventive medicine division new chief: Colonel Bedwell, 1466
School of Aviation Medicine, graduates, 46; 1194
AVITAMINOSIS: See Vitamins, deficiencies
AVOCATIONS: See Physicians, avocations
AWARDS: See Prizes
AZOSPERMIA: See Spermatozoa
AZULFIDINE: See Salicylazosulfapyridine

B

B Compound: See Corticosterone
B Vitamins: See Vitamins B Complex
BCG Vaccination: See Tuberculosis, immunization, BCG
BAL: See Dimercaprol
BABIES: See Infants
BACCALAUREATE Degrees: See Degrees
BACILLARY DYSENTERY: See Dysentery
BACILLUS: See Bacteria
BACIMYCIN: See Bacitracin-Neomycin
BACITRACIN
N.N.R., (Pfizer) 1447
treatment to control surgical infections, [Meleney & Johnson] *1253
BACITRACIN-NEOMYCIN (Bacimycin)
name accepted by Council, 801
BACK: See Spine
Pain in: See Backache
BACKACHE: See also Spine, intervertebral disk
etiology: retroperitoneal tumor [Anderson] 1052—ab
pathogenesis: lipoma syndrome in sacral region, [Schmidt-Voigt] 598—ab
BACTEREMIA: See Meningococcemia
BACTERIA: See also Staphylococcus; Streptococcus; Tubercle Bacillus; under names of organs and regions
abortus Infection: See Brucellosis
contaminants, that may prove fatal in banked refrigerated blood, 74
count in crushed ice controlled with chlorine solution, 1101—E
count (normal) in operating rooms, 775
drug resistant, during isonicotinic hydrazides treatment [Coates] 593—ab
Dysenteriae Flexner: See Shigella
gram-negative, contaminated blood for transfusion, causes shock, [Braude] 585—ab
in chronic bronchitis, [May] 1487—ab
Infection: See Infection
Lactobacillus Casei Factor (Synthetic): See Acid, folic
recontamination of washed bedding in laundries, [Church] 756—ab
sensitivity to antibiotics in surgical infections, [Meleney & Johnson] *1253
BACTERICIDES: See Antisepsis; Sterilization, Bacterial
BACTERIOLOGIC WARFARE: See Biologic Warfare
BACTERIUM: See Bacteria
BAL: See Dimercaprol
BALDNESS: See Alopecia
BALLISTICS
firearm accidents, prevention, 1365—E
BALLISTOCARDIOGRAM
effects of exercise and smoking, [Davis] 1478—ab
BALLOON
free, ascent to 72,395 feet, [La Gorce] 974—C
tamponage to control bleeding esophageal varices, 1286—E
BALSAM
Peruvian, with dried blood plasma for decubitus ulcers, [Clark & Rusk] *787
BANDAGES: See Dressings
BANG'S Disease: See Brucellosis
BANKS (therapeutic): See Blood Transfusion; Bones; Eyes
BANTHINE: See Methantheline
BANTI'S Disease: See Splenomegaly
BARBITURATES: See also Butabarbital; Secobarbital
poisoning (chronic addicts), [Milburn] 1056—ab
poisoning (fatal), percentage under medical examiner or coroner system, [Turkel] *1089
poisoning with barbituric acid causes cerebral edema, serum albumin and picrotoxin for, [Mousel] *459
BARIETY Technic: See Mediastinum, roentgen study
BARIUM
enema apparatus for roentgen examination of colon, [Hodges] *1420
BARRÉ-Guillain Syndrome: See Guillain-Barré Syndrome
BASAL Metabolism: See Metabolism, basal
BASEBALL
"pitcher's elbow," 74
BASEDOW'S Disease: See Goiter, Toxic
BASIC SCIENCES
schools of, approved, in U. S. and Canada, *116; (descriptive list) *147
schools of, enrollment by classes of veterans and non-veterans, *126
schools of, range of annual fees, *130
schools of, residence of freshmen, *127
schools of, statistics on students in, 1931-1953, *118
schools of, vacancies in instructional staffs, *132
BAT: See Bats
BATHS: See Swimming
BATS
rabies in, Pa., 1104
BAYNE-JONES, STANHOPE, receives "supergrade" in army medical service, 1035
BCG Vaccination: See Tuberculosis, immunization
BEANS
cut green, Comstock Brand Dietetic Pack, 1099
cut green, lima, cut wax, Matchless Brand Dietetic Pack, 217
BEAUMONT, WILLIAM (1785-1853)
medicine, warfare, and history, [Fulton] *482
memorial to, cornerstone for, Mich., 735
BEAUTY PREPARATIONS: See Cosmetics
BECHTEREW'S DISEASE
treatment, thorium X, [Erlacher] 1594—ab
BECK Operations: See Arteries, coronary
BED
Capacity: See Hospitals
Emerson Rocking Bed, Standard Hospital Model, 33
BEDDING
washed in laundries, recontaminated, [Church] 756—ab
BEDSORES: See Decubitus
BEECH-NUT PRODUCTS
Junior Sweet Potatoes, 1099
BEETLES
tumors found in rats injected with carcinogenic quinones from, [Spies] *189; *190
BEETS
sliced, Matchless Brand Dietetic Pack, 217
BEHAVIOR: See also Mental Health; Personality; Psychosomatic Medicine
changes in children subjected to tonsillectomy, 493—E
Malamud-Sands Worchester rating scale in aged after drug therapy, [Levy] *1260
BELGIAN
Red Cross: See Red Cross
BELGIAN CONGO
cutaneous and venereal diseases in, 873
psychiatry in, 873
BELING Lecture: See Lectures
BENADRYL: See Diphenhydramine
"BENDS": See Caisson Disease
BENOXINATE HYDROCHLORIDE (Dorsacaine)
name accepted by Council, 801
BEQUESTS: See Donations (cross reference)
BENZAZOLINE: See Tolazoline Hydrochloride
BENZEDRINE: See Amphetamine
BENZENE HEXACHLORIDE
gamma, hazard of insecticide 992
gamma, N. N. R., (Chemo Puro) 727
BENZETHONIUM CHLORIDE (Phemerol Chloride)
N. N. R., (Chemo Puro) 727
BENZOFOSFAN I. C. I.
phosphorus combined with vitamin B_1 [Ronconi] 599—ab
BENZOHYDRYL Alkamine Ethers: See Diphenhydramine
BENZOTROPINE
sulfonate treatment of parkinsonism, [O'Doherty] 63—ab
BENZPYRINIUM BROMIDE (Stilmonene)
treatment of postoperative urinary retention, [Weinstein & Roberts] *268
BERIBERI
heart disease, [Benchimol] 879—ab
BERSON, R. C., MEDICAL SCHOOLS IN U. S. AT THE MIDCENTURY, *106; 149—E; (review) 1325
BERYLLIUM
beryllosis, [DeNardi] 675—ab
granuloma of skin, nonsurgical treatment, [Fisher] 1119—ab
poisoning registry at Massachusetts General Hospital, [Hardy] 509—C
BESNIER-Boeck-Schaumann Disease: See Sarcoidosis
BEVERAGES: See also Milk; Water
Alcoholic: See Alcohol
quinine water, tinnitus from [Yohalem] 1304—C
BEVERIDGE Plan: See National Service Plan (England)
BEZOAR
diospyrobezoar, [O'Leary] 587—ab
phytobezoar from eating wild dates, Turkey, 1471
BIBLIOGRAPHY: See American Medical Association, Quarterly Cumulative Index Medicus
BIFACTION: See under Cyanocobalamin
BILE DUCTS: See also Gallbladder; Liver
perforation (nontraumatic), Brazil, 47
roentgen study (operative) shows congenital absence of gallbladder, [Malström] 1485—ab
roentgen study, percutaneous transhepatic cholangiography, [Nurick] 1583—ab
BILHARZIASIS: See Schistosomiasis
BILIARY TRACT: See also Bile Ducts; Gallbladder; Liver
peritoneoscopic cholangiography, 856—E
BILLINGS Lecture: See Lectures
BILLROTH'S POSTULATES
multiple malignant neoplasms, [Arenas] 1590—ab
BILLS: See Fees
Legislative: See Laws and Legislation
BIOLOGIC WARFARE
plans for special defense weapons, 859
BIOPSIES: See Liver; Prostate
Needle: See Kidneys
Punch: See Liver
BIOSTATISTICS: See Vital Statistics
BIRTH: See also Labor
hour of birth, relation to onset of labor, 583
in Hospital: See Hospitals, maternity
Multiple: See Twins
Palsy: See Paralysis, cerebral
Premature: See Infants, premature
Stillbirth: See Stillbirth
BIRTH CONTROL: See Contraception
BIRTHMARKS: See Nevus

V 15
1953

BISHYDROXYCOUMARIN (Dicumarol)
coronary vasodilators evaluated, [Russek & others] *207
hemorrhage from self-medication with, [Cosgriff] *547
prevent postoperative thromboembolism, [Milch] 1204—ab
treatment and PID compared, Norway, 876
treatment, control by Owren's method in thromboembolic diseases, [Lund] 602—ab
treatment during pregnancy; effect on fetus and newborn, 1142
treatment, long-term, of coronary thrombosis and other thromboembolic disorders, [Lund] 602—ab
BISMUTH
Glycolylarsanilate: See Glycobiarsol
Treatment: See Neurosyphilis
BISTRIUM: See Hexamethonium
BLADDER: See also Urachus; Urinary System
anatomy and nerve supply, [Van Duzen & Duncan] *1345
cancer, segmental cystectomy in, [Gammelgaard] 523—ab
Cord: See Bladder, paralysis
diverticula and obstruction, urinary tract infection due to, 1497
dysfunction in women, [Carson] *1152
Fistula: See Fistula
irritation (chronic) in females, [O'Brien & Mitchell] *1149
lesions, gross hemorrhage as symptom, [Lee & Davis] *782
megalobladder, cause of urinary retention in children, [Powell] *1341
Neurogenic: See Bladder, paralysis
paralysis, A. M. A. Section on Urology symposium on neurogenic bladder, [Thompson] *1337; [Powell] *1341; [Van Duzen & Duncan] *1345
paralysis in congenital spinal meningocele, [Jaeger] *792
paralysis, management of cord bladder, [Thompson] *1337
BLASTOMYCOSIS: See also Chromoblastomycosis
complicating tuberculosis; treated with ethyl vanillate, iodine, streptomycin, stilbamidine, [Stillians & Klemptner] *560
BLEB: See Blister
BLEEDERS: See Hemophilia
BLEEDING: See Hemorrhage
BLINDNESS: See also Vision
causes of, in England, 1469
Night: See Night Blindness
parents of blind children form organization, Vt., 1458
BLISTER
abnormal air spaces in the lungs, [Mayer & Rappaport] *700
BLOOD
afibrinogenemia causes postpartum hemorrhages [Vecchietti] 1591—ab
Albumin: See Blood proteins
alcohol concentration, (correction) 439
alcohol concentrations vs. time of drinking wine, [Serianni] 521—ab
Bank: See Blood Transfusion,
borne tumor metastases, [Coman] 242—ab
calcium, hypercalcemia, complicating hormone therapy in breast cancer, [Kennedy] 243—ab
Cells: See also Erythrocytes; Leukocytes
cells, pancytopenia in occult subacute bacterial endocarditis, [Parsons] 881—ab
changes in liver cirrhosis, Chile, 1036
chemistry in persistent vomiting during pregnancy, [Lans & others] *1012
cholesterol, hypercholesteremia in hospital population, [Schaefer] 513—ab
cholesterol, hypercholesteremia, myxedema, and atherosclerosis, [Blumgart] 239—ab
Circulation: See also Blood volume; Pulse; Vasomotor System
circulation (abnormal), morphological bases, internists discuss, Italy, 505
circulation, dynamics in mitral stenosis, [Blacket] 1126—ab
circulation, effect of Valsalva maneuver, [Eisberg] 169—ab
circulation, muscle blood flow determined by radiosodium clearance, [Wisham & others] *10
Clot: See Blood coagulation; Blood prothrombin; Thrombophlebitis; Thrombosis
Clotting: See Blood coagulation
Coagulation: See also Blood prothrombin; Hemophilia
Coagulation, Anticoagulants: See Anticoagulants
coagulation, action of human gastric juice on blood clots, [Barkham] 882—ab
coagulation, effect of antihistamines in, 1229
coagulation in cardiovascular diseases, [Weis] 70—ab
coagulation, role of platelets, [Zucker] 1041—C
coagulation, studies of, especially on proconvertin and convertin, [Lund] 602—ab; 662; 876
Coughing Up: See Hemoptysis
Donors: See Blood Transfusion

BLOOD—Continued
Dyscrasia: See also Agranulocytosis; Anemia; Anemia, Pernicious; Erythroblastosis, Fetal; Leukemia; Polycythemia
dyscrasia after gold therapy, [Watson] 686—ab
dyscrasia, progress in treatment, Italy, 1037
Eosinophils Circulating in: See Eosinophils
factor U, fatal hemolytic transfusion reaction from, [Wiener & others] *1444
Flow: See Blood circulation
fractionation, advanced during World War II, [Fulton] *482
Groups: See also Rh Factor
groups chimera, [Dunsford] 765—ab
groups, fatal transfusion reaction from factor U, [Wiener & others] *1444
groups, hemolytic disease of newborn due to ABO incompatibility, [Dunn] 448—ab
groups, preventing transfusion accidents, pathologists report, London, 875
groups, typing infants and newborn for transfusions, 527
Hemoglobin: See Hemoglobin
in Feces: See Melena
in Urine: See Hematuria
infection: See Meningococcemia
Infusion: See Blood proteins; Blood Transfusion
Injection of Whole Blood or Its Derivatives: See Blood Transfusion; Hemotherapy;
Loss of: See Hemorrhage
Menstrual: See Menstruation
penicillin, serum levels after administration, [Huang] 244—ab
picture after operation for portal hypertension, [Macpherson] 252—ab
picture in morphyria, [Trainito] 1589—ab
Plasma: See Plasma; specific subheads under Blood; Blood Transfusion
Platelets: See also Purpura, thrombopenic
platelets, role in arresting hemorrhage, [Zucker] 1041—C
platelets, thrombocytes in allergic processes, [Storck] 1132—ab
potassium, hyperpotassemic paralysis, [Bull] 766—ab
potassium, hypokalemia from persistent vomiting in pregnancy, [Lans & others] *1012
potassium, hypopotassemia in Cushing's syndrome, [Sprague] 449—ab
potassium, hypopotassemia, symptoms, 184—ab
potassium, lowered with insulin and glucose, [James & others] *545
potassium (serum), rapid simple test with sodium cobaltinitrite, [Keitel & Keitel] *799
potassium, treatment of hyperkalemia in acute renal failure, [Knowles] 1119—ab
Preserved: See Blood Transfusion
Pressure: See BLOOD PRESSURE
Proteins: See also Globulin, gamma
proteins from cattle, intravenous infusion of Adaequan in man, [Grüning] 981—ab
proteins, hypoalbuminemia in complications from mercurial diuretics, [Diengott] 252—ab
proteins, hypoalbuminemia in kwashiorkor, (Council article) [Williams] *1282
proteins, hypoproteinemia in glomerulonephritis, [Keith & Odel] *1240
proteins, hypoproteinemia in paraplegia, [O'Donnell & Gardner] *709
proteins (plasma or serum) in rheumatic fever, [Jackson] 1574—ab
proteins, 25% salt-poor human serum albumin treatment of barbituric acid poisoning, [Mousel] *459
proteins, globulin value in multiple myeloma, 1598
Prothrombin: See also Blood coagulation
prothrombin, hypoprothrombinemia, from self-medication with bishydroxycoumarin, [Cosgriff] *547
prothrombin-proconvertin determination (Owren's) in thromboembolic diseases, [Lund] 602—ab; 662; 876
Serum: See various subheads under Blood
Substitute: See Plasma expanders
Sugar: See also Diabetes Mellitus
sugar findings, diagnostic significance, [McLoughlin & others] *182
sugar, glucagon, hyperglycemic glycogenolytic factor of pancreas, [de Duve] 887—ab
sugar levels (weekly fasting) of pregnant diabetic women, [Tolstoi & others] *999
sugar, spontaneous hypoglycemia from insulinoma, [de Peyster] 1478—ab
supply of malignant pulmonary neoplasms, [Cudkowicz] 985—ab
Test: See also Syphilis, serodiagnosis
test (West-Hilliard) for cancer, 1229
Transfusion: See BLOOD TRANSFUSION
Types: See Blood groups
U Factor: See Blood, factor U
urea concentration as renal function test, [Goldring] *1246
Vessels: See BLOOD VESSELS
vitamin B12 (serum) in megaloblastic anemia, [Mollin] 1485—ab
Volume: See also Blood circulation

BLOOD—Continued
volume expander: clinical evaluation of dextran, [Bowman] *24
volume studies in normal men, [Brady] 521—ab
Vomiting of Blood: See Hematemesis
BLOOD PRESSURE
diastolic, disappearing, as sign of rupture of aortic valve, [Bean & Schmidt] *214
in persons 65 and over, study by New York Heart Assn., [Master] 1115—C
in steatorrhea, [de Langen] 1324—ab
low, *l*-arterenol in acute hypotensive states, [Barlow] 1132—ab
low, diastolic, after brain injuries, 456
low diastolic in certain types of brain injury, (reply) [Brings] 1068
low, hypotensive anesthesia, [Brunschwig] 1056—ab
low, hypotensive anesthesia in plastic surgery, [Bentel] 601—ab
low, labyrinthic hypotension, Paris, 663
low, liver and kidney function in hexamethonium-induced hypotension, [Schweizer] 1213—ab
lowering by spinal injection of blood, [Heimark] 592—ab
Portal: See Portal Vein
reactions to effort and cold, Chile, 969
relation to physical constitution, [Russo] 1218—ab
BLOOD PRESSURE, HIGH
cause of death in physicians, [Poynton] 1379—C
complications: asthma; epinephrine treatment advisable? 1496
complications: glomerulonephritis, [Keith & Odel] *1240
coronary occlusion and, [Master] 1122—ab
eosinophils and lymphocytes in, [Taquini] 70—ab
essential, course and prognosis, 10-year follow-up, [Palmer & Muench] *1
etiology: endangiitis obliterans of kidney, [Fellmann] 768—ab
etiology: familial bilateral pheochromocytoma, [Roth] 676—ab
etiology: pheochromocytoma, [Hartl] 770—ab
etiology: renal and adrenal factors, [Wilson] 1587—ab
headache and, [Stewart] 687—ab
in child, bleeding esophageal varices only sign, [Mithoefer] *1097
in infant with Wilms' tumor, 1597
malignant, [Heptinstall] 600—ab; 774
malignant, hypophysectomy in man, [Luft] 171—ab
malignant, pancreas lesions in, [Hranilovich] 238—ab
obesity in relation to, [Master & others] *1499
panel on hypertensive cardiovascular disease, Ill., 1026
Portal Hypertension: See Portal Vein
prognosis in 25 year old woman with hypertension since 14, 1141
pulmonary, patent ductus arteriosus with [Hultgren] 681—ab; [Chávez] 764—ab
sclerotherapy for varicose veins contraindicated in? 1141
treatment, adrenalectomy and sympathectomy in essential type, [Zintel] 1403—ab
treatment, adrenalectomy and sympathectomy in severe type, [Jeffers] 880—ab; [Jeffers & others] *1502
treatment, ganglioplegics in essential type, [Bartorelli] 1321—ab
treatment, hexamethonium chloride, [Hirschleifer] 64—ab
treatment, hexamethonium injection, [Morrison] 524—ab
treatment, hydergine, [Wilbrandt] 166—ab
treatment, hydralazine and hexamethonium, [Hilker & others] *5
treatment, hydrazinophthalazine preparations, [Kummer] 887—ab
treatment, methonium salts and hydrazinophthalazine, [Groh] 1123—ab
treatment of essential type, 1092—ab
treatment, protoveratrine, use in pregnancy, [Meilman] *543
treatment, thyroid extract, [Bradlow] 1593—ab
BLOOD TRANSFUSION: See also Medicolegal Abstracts at end of letter M
accidents, how to prevent, report by pathologists committee, London, 875
banked refrigerated blood, contaminants that may prove fatal in, 74
banked (stored) blood, complications from toxins in, [Heilmeyer] 983—ab
blood donors, hematocrit and hemoglobin response, [Cole] 591—ab
blood stored below 32 F in liquid state, [Lorant] 1577—ab
complications: danger from blood mixed with dextrose, 1597
complications: fatal reaction from blood factor U, report of case, [Wiener & others] *1444
complications: synthetic antihistamines in reactions, [Catalano] 1488—ab
exchange, in hemolytic disease of newborn, [Sacks] 1570—C

BLOOD TRANSFUSION—Continued
International Blood Transfusion Society, meeting, 41
of blood contaminated with gram-negative bacilli causes shock, [Braude] 585—ab
platelet transfusion in postirradiation hemorrhagic state, [Woods] 242—ab
stress effect of, [Möller] 770—ab
Subcommittee on Medicolegal Aspects of, (report) 836
transmission of hepatitis by blood and plasma transfusions, [Hässig] 254—ab
typing infants and newborn for, 527
BLOOD VESSELS: See also Aorta; Arteries; Capillaries; Vasomotor System; Veins
Disease: See Arteriosclerosis; Cardiovascular Disease; Phlebitis; Raynaud's Disease; Thrombophlebitis; Varicose Veins
murmurs, and peripheral circulatory disturbances, [Holldack] 686—ab
roentgen study, fatal iodopyracet complications, [Utterback] 171—ab
Transposition of the Great Vessels: See Heart anomalies
tumors of skin, spontaneous involution, [Ronchese] 1575—ab
BLUM (Theodor) Price: See Prizes
BOARD: See also under specific names as Advisory Board; American Board; National Board; State Board
of Health: See Health
of Thoracic Surgery, (requirements; certification; fees) *428
of Trustees: See American Medical Association
BODY
Build: See Constitution
Dead, Examination of: See Autopsies
Growth of: See Growth
Heat, Production: See Metabolism, basal
Organs: See Viscera
Temperature: See Fever; Temperature, Body
Weight: See also Obesity
weight (standard), incidence of coronary disease and hypertension [Master] *1500
BOECK'S Sarcoid: See Sarcoidosis
BOILS: See Furunculosis
BOLEN test for cancer, 1560
BOMBS
Atomic: See Atomic Energy
BOND, THOMAS (1712-1784)
described teaching rounds in 1766, [Armstrong] *85
BONE MARROW: See also Myeloma; Osteomyelitis
changes after splenic irradiation in leukemia, [Gunz] 1049—ab
myelosclerosis, [Beattie] 1217—ab
neoplastic cells in, [Kleimans] 1130—ab
BONES: See also Cranium; Orthopedics; Osteo- - -; Ribs; Spine; under names of specific bones
Atrophy: See Osteoporosis
bank, 1508—ab
cancer, changes in skeletal metastases, [Stein] 883—ab
changes in paraplegia, [O'Connell & Gardner] *710
Dystrophy: See Osteodystrophy
Fracture: See Fractures
Fragility: See Fragilitas ossium
lesions (multiple) in Letterer-Siwe disease, [Fisher] 62—ab
preservation of living bone in plasma, [Tucker] 66—ab
skeletal deformity after poliomyelitis, preventing [Bennett] *79
skeletal fluorosis, spinal compression from, [Murthi] 983—ab
tumors, sarcoma in children, raw egg yolks plus X-rays for, [Krebs] 1408—ab
BOOKS: See also Journals; Library; Literature; Book Reviews at end of letter B
autographing by German professor for American medical officer in Jena, [Wartenberg] 1115—C
Mountin Memorial Volume, 1371
shipped to Korea, [Rusk] 509—C
BOOTS: See Shoes
BORDEN Award: See Prizes
BORNHOLM Disease: See Pleurodynia, Epidemic
BOTALLO'S Duct: See Ductus Arteriosus
BOTTLES
plastic reagent, for alkalis, [Cornbleet] 1571—C
BOUIN'S SOLUTION
examination of tissue sections, (replies) [Pickard] 1328
BOWEL MOVEMENT: See Feces
BOWELS: See Intestines
BOXING
fatalities attributed to, 455
BRAATY, TRYGVE, death, Norway, 1471
BRACES
corrective, for upper extremity in hemiplegia, [Rudin & others] *479
BRACHIAL PLEXUS
avulsion, 6 cases, [Jaeger & Whiteley] *633
BRAIN: See also Cranium; Head; Meninges; Nervous System
aneurysms (cirsoid and arteriovenous), [Petit-Dutaillis] 888—ab
aneurysms complicating polycytic kidneys, [Bigelow] 58—ab
BRAIN—Continued
aneurysms of circle of Willis, [Norlén] 758—ab
anoxia and causation of epilepsy, [Courville] 679—ab
anoxia in aged, drug therapy, [Levy] *1260
complications after smallpox vaccination, [Miller] 512—ab
complications of rubella, 258
diagnosis of intracranial mass lesions, [Martin] 757—ab
diencephalohypophysial dysregulation: obesity, [Kossmann] 1127—ab
Disease: See Epilepsy; Mental Disorders; Paralysis agitans
edema in barbituric acid poisoning; treated with human serum albumin and picrotoxin, [Mousel] *459
electroencephalography in diagnosis of epilepsy, [Buchthal] 986—ab
hemorrhage, incipient apoplexy, aminophylline intravenously for, [Mainzer] 1405—ab
hemorrhage, is stellate ganglion block of value in stroke? [Ruben & Mayer] *1002
hemorrhage, treatment, [Cossa] 71—ab
Inflammation: See Encephalitis; Meningoencephalitis; Polioencephalitis
injection of procaine into frontal lobes for obsessive-compulsive reaction, [Myers & others] *1015
injuries from atomic bombardment, [Uchimura] 171—ab
injuries, low diastolic pressure after; also "jerk" in other leg on patellar reflex examination, 456; (reply) [Brings] 1068
meningeal reaction (fatal late) to ethyl iodophenylundecylate, [Erickson & van Baaren] *636
roentgen visualization (accidental) of ventricles months after thorotrast injection, [Leader] 65—ab
Softening: See Encephalomalacia
surgery, hemispherectomy in cerebral palsy, [Beller] 252—ab
surgery, lobotomy and epilepsy, [Freeman] 592—ab
surgery, lobotomy, prognosis, Sweden, 1569
surgery, prefrontal lobotomy: follow-up of 125 patients, [Kryger] 1060—ab
surgery, orbital leukotomy, [Tow] 1587—ab
surgery, selective lobotomy for intractable pain, [Grantham] 167—ab
surgery, separation in craniopagus (Brodie twins), [Grossman & others] *1201
surgery, Treatment of Mental Illness by Topectomy (film review), 1044
syndrome in aged patients in state mental hospital, [Levy] *1260
Syphilis: See Neurosyphilis
tumors, survey of 1,733 cases at University of Pennsylvania, [Grant] *22
BRAUN PENETROMETER
measurement of contraceptive viscosity correlated with Hobblometer times, (Council article) [Gamble] *1021
BREAD
return to white bread, London, 1378
BREAST
cancer after hormone therapy, [Emerson] 680—ab
cancer (bilateral), [Reese] 67—ab
cancer, biologic variability [Black] 684—ab
cancer, conservative and radical surgery, [Williams] 1584—ab
cancer, lung metastases from, [Stoll] 1584—ab
cancer, early diagnosis, [Kreyberg] 1129—ab
cancer, estrogen excretion before and after adrenalectomy, [Dao] 761—ab
cancer, hypercalcemia complicating hormone therapy, [Kennedy] 243—ab
cancer in Israeli women, [Kook] 765—ab
cancer in pregnancy, (Check) 56—ab
cancer in pregnancy, irradiation for, [Kaplan] 64—ab
cancer, influence of age, marriage, and other factors, Norway, 663
cancer, lecture on, New York, 650
cancer, oophorectomy and, 1231
cancer, papillary disease and nipple discharge relation to, [Kilgore] 66—ab
cancer, radical mastectomy with and without x-ray, [Smith] 1581—ab
cancer, recurrences and metastases in [Hoffert] 1121—ab
cancer, small tumor in, [Kreyberg] 769—ab
cancer, statement by Dr. Wermer on, before U. S. House Committee 731
cancer, surgical treatment at Johns Hopkins Hospital, 1935-1940, [Lewison & others] *905
cancer, X-ray irradiation for, [Heilig] 255—ab
disorders, androgen therapy, Italy, 1468
Feeding: See Infants, feeding; Lactation
Milk: See Lactation
nipple discharge, relation to cancer, [Kilgore] 66—ab
surgery, conservative and radical, in cancer [Williams] 1584—ab
surgery, Dr. Franklyn enlarges immature breast with polyvinyl sponge, 1200—BI
surgery for cancer at Johns Hopkins Hospital, 1935-1940, [Lewison & others] *905
BREAST—Continued
surgery, internal mammary coronary artery anastomosis, [Vineberg] 238—ab
surgery, radical mastectomy with and without primary X-ray for cancer, [Smith] 1581—ab
surgery, survival after mastectomy, [Harrington] 517—ab
tumors, sarcoma, [Monnoyer] 596—ab
BREASTPLASTY
by Dr. R. A. Franklyn, 1200—BI
BREATH: See Respiration
BREATHING: See Respiration
Artificial: See Respiration, artificial
BRICKER: Amendment: See Treaties
BRIGHT'S Disease: See Nephritis
BRITISH: See also Imperial
Anti-Lewisite: See Dimercaprol
Columbia, University of: See University
Government, National Health Service: See National Health Service
Health Service: See National Health Service
Medical Association, (host at World Conference on Medical Education) 492—E; (specter of nationalization) 446; (review of general practice by committee) 1195; (standard for physician's office) 1302
Medical Register, number of names in, 1378
Medical Research Council: See Medical Research Council
Medical Students' Ass'n: "Survey of the General Practitioner Schemes in Operation in British Medical Schools", 445
Pharmacopoeia, 1953, changes in, 1378
BROADCASTING: See Radio; Television
BRODIE TWINS
surgical separation in craniopagus, [Grossman & others] *201
BROMSULPHALEIN: See Sulfobromophthalein
BRONCHIECTASIS
associated with asthma, Sweden, 49
BRONCHITIS: See also Laryngotracheobronchitis
acute, carbomycin (magnamycin) for [Hewitt] 1053—ab
Asthmatic: See Asthma
chronic, bacteriology of, [May] 1487—ab
BRONCHOGRAPHY: See Bronchus, roentgen study
BRONCHOPNEUMONIA
treatment, artificial hibernation, France, 1197
BRONCHUS: See also Bronchiectasis; Bronchitis
aspiration, simple device for, [Emerson] *920
cancer (bronchogenic), cell types in [Moersch] 243—ab
cancer (bronchogenic), operative treatment, Denmark, 581
cancer (bronchopulmonary), statistics, [Gagnon] 986—ab
cancer, improved results in treatment [Hansen] 690—ab
cancer, increase in, [Denk] 596—ab
cancer, radioactive cobalt in postoperative treatment [Schneidrzik] 764—ab
cancer simulating virus pneumonia, [Custer] 1318—ab
endobronchial method to increase bacilli in sputum, [Fourestier] 601—ab
endobronchial perforations of lymph nodes, [Canestrini] 1490—ab
obstruction (congenital), mucocele of lung due to, [Ramsay] 590—ab
roentgen localization of segments with laminagraphy, [Adler] 1047—ab
roentgen study with lipoidol vaporization, [Girard] 888—ab
tumors, peripheral and multiple, [Felton] 60—ab
BRONFENBRENNER, J. J., death, 1104
BRUCELLA
abortus Strain 19 Vaccine: See Brucellosis
BRUCELLOSIS
caseation necrosis in, [Crow] 241—ab
diagnosis, serologic diagnosis, [Fey] 985—ab
etiology: strain 19 vaccine in 2 veterinarians, [Spink & Thompson] *1162; 1176—E
in man, [Hall] 173—ab
trace elements in, (Council article), [Berman] *643
WHO Expert Committee report on, 1176—E
BRUIT: See Noise
BUBO
Climatic: See Lymphogranuloma, Venereal
BUFFALO
University of: See University
BUILDINGS: See Hospitals
BULBAR Poliomyelitis: See Poliomyelitis
BULLA: See Blister
BURDICK (Ward) Award: See Prizes
BUREAU
A. M. A.: See American Medical Association
BURKE (William) Award: See Prizes
BURNING Pain: See also Causalgia; Erythromelalgia
sensation in esophagus after gastrectomy, 1597
sensation in mouth, 1498
BURNS
chromoblastomycosis after, [Barwasser] *556
of hand with acetylene blowtorch, 1415
shock, polyvinylpyrrolidone in, [Cordice] 522—ab

V 15
1953

BURNS—Continued
treatment, [Schjelderup] 1589—ab
treatment, assessment, [Moyer] 167—ab
treatment, dextran, [Johnston] 166—ab
treatment, effect of chlorophyll on wound healing, [Lam] 1571—C
treatment, plastic dressings, Sweden, 1569
BURTON-Hill Hospital Survey and Construction Act: See Hospitals, building program
BUSINESS PRACTICE
determining the fee, *1118; (8 rules) *1202; (adjustment of fees) *1309; (discussion of fee) *1477
office management, *1045
to help the patient pay, *1573
BUTABARBITAL SODIUM
N. N. R., (Bowman) 1447
BUTAFYRIN: See Phenylbutazone
BUTAZOLIDIN: See Phenylbutazone

BOOK REVIEWS

Abbatt, J. D., and others, Künstliche radioaktive Isotope in Physiologie, Diagnostik und Therapie, 73
Abdomen
Local Analgesia: Abdominal Surgery, [Macintosh & Bryce-Smith] 73
Achievement
Age and Achievement, [Lehman] 1065
Ackerknecht, E. H., Rudolf Virchow: Doctor, Statesman, Anthropologist, 1410
Ackerman, L. V., Surgical Pathology, 1494
Adams, A. R. D., and Maegraith, B. G., Clinical Tropical Disease, 1413
Adams, R. D., Denny-Brown, D., and Pearson, C. M., Diseases of Muscle: Study in Pathology, 1227
Adaptation Syndrome
Recent Progress in Hormone Research: Proceedings of Laurentian Hormone Conference, [Pincus] 1140
Adenoma
Pituitary Chromophobe Adenomas, [Nurnberger & Korey] 1140
Adrenals
Recent Progress in Hormone Research: Proceedings of Laurentian Hormone Conference, [Pincus] 1140
Suprarenal Cortex, [Yoffey] 987
Adventures in Artificial Respiration [Karpovich] 987
Aero Medical Association
Aviation Toxicology, 1134
Age and Achievement, [Lehman] 1065
Aged: See Old Age
Alcoholism
European Seminar and Lecture Course on Alcoholism, [WHO] 1492
Allergy
Contact Dermatitis, [Waldbott] 891
Immunity: Hypersensitivity, Serology, [Raffel] 72
American Academy of Orthopaedic Surgeons Instructional Course Lectures, Volume X., [Pease] 988
American Association of Clinical Chemists
Standard Methods of Clinical Chemistry, Volume I, [Reiner] 1495
American College of Surgeons
Surgical Forum, [Wangensteen] 1134
American Medical Association
New and Nonofficial Remedies, 1413
Tests and Standards for New and Nonofficial Remedies, 1326
Ampulla of Vater: See Vater's Ampulla
Anatomy: See also Pathology; Physiology
Functional and Surgical Anatomy of the Hand, [Kaplan] 177
Human Neuroanatomy, [Strong & Elwyn] 1138
Lehrbuch der topographischen Anatomie, [Hafferl] 1326
Manual of Comparative Anatomy, [Breland] 526
Anderson, A. K., Essentials of Physiological Chemistry, 72
Anesthesia
Conduction Anesthesia, [Pitkin] 773
History of Anesthesia: With Emphasis on the Nurse Specialist, [Thatcher] 256
Local Analgesia: Abdominal Surgery, [Macintosh & Bryce-Smith] 73
Trichloroethylene Anaesthesia, [Ostlere] 73
Annual: See Yearbook
Antibiotics
Sulphonamides and Antibiotics in Man and Animals, [Lawrence] 1493
Arnow, E., Introduction to Physiological and Pathological Chemistry, 1325
Arteriosclerosis
Experimental Atherosclerosis, [Katz & Stamler] 1139
Arthritis
Your Arthritis: What You Can Do About It, [Phelps] 256
Atlas
Atlas of Commoner Skin Diseases, [Semon] 1410
Atlas of Medical Mycology, [Moss & McQuown] 256
Atlas of Regional Dermatology, [Stratton] 1409
Atlas—*Continued*
Atlas of Surgical Exposures of Extremities, [Banks & Laufman] 772
Die Wirbelsäulentuberkulose und ihre Differential diagnose, [Brocher] 1139
Tumors of Bone: Roentgenographic Atlas, [Coley & Higinbotham] 890
Atomic Defense
Physician in Atomic Defense, [Sears] 1135
Atomic Medicine, [Behrens] 1495
Aviation
Aviation Toxicology, [Aero Medical Association] 1134
Green and Red Planet, [Strughold] 1410
Back
Man's Back, [Willis] 1133
Bainton, R. H., Hunted Heretic: Life and Death of Michael Servetus, 1511-1553, 1596
Ballistocardiography
Ballistocardiogram: Dynamic Record of the Heart Beat, [Braunstein] 1409
Ballistocardiography, [Dock & Others] 1062
Banks, S. W., and Laufman, H., Atlas of Surgical Exposures of the Extremities, 772
Barcroft, H., and Swan, H. J. C., Sympathetic Control of Human Blood Vessels, 454
Barnard, W. G., Elementary Pathological Histology, 1596
Barnes, J. M., Toxic Hazards of Certain Pesticides to Man, 889
Barraquer Ferré, L., Estudios de neurología clínica, 1134
Beeson, P. B., editor, Year Book of Medicine (1953-1954 Year Book Series), 1493
Behrens, C. F., editor, Atomic Medicine, 1495
Belcher, J. R., and Grant, I. W. B., Thoracic Surgical Management, 526
Biggs, R., and Macfarlane, R. G., Human Blood Coagulation and Its Disorders, 1140
Biochemistry
Isotopic Tracers in Biochemistry and Physiology, [Sacks] 1139
Biography: See Physicians
Blacklock, A. L. J., and Southwell, T., Guide to Human Parasitology, 1493
Blood
Human Blood Coagulation and Its Disorders, [Biggs & Macfarlane] 1140
Blood Vessels
Nomenclature and Criteria for Diagnosis of Diseases of Heart and Blood Vessels, [Pardee] 891
Sympathetic Control of Human Blood Vessels, [Barcroft & Swan] 454
Bodian, M., and others, editors, Fibrocystic Disease of the Pancreas: Congenital Disorder of Mucus Production—Mucosis, 1135
Bones
Tumors of Bone: Roentgenographic Atlas, [Coley & Higinbotham] 890
Book of Health: Medical Encyclopedia for Everyone, [Clark & Cumley] 1228
Bower, A. G., and Pilant, E. B., Communicable Diseases: Textbook for Nurses, 1065
Brain
Neurophysiological Basis of Mind: Principles of Neurophysiology, [Eccles] 989
Braunstein, J. R., Ballistocardiogram: Dynamic Record of the Heart Beat, 1409
Breckinridge, K. L., Effective Use of Older Workers, 1064
Breland, O. P., Manual of Comparative Anatomy, 526
British Empire: See Great Britain
British Pharmacopoeia 1953, [General Medical Council] 1063
British Postgraduate Medical Federation
Lectures on the Scientific Basis of Medicine, Volume 1: 1951-52, 454
Brocher, J. E. W., Die Wirbelsäulentuberkulose und ihre Differentialdiagnose, 1139
Brock, S., Basis of Clinical Neurology, 454
Brodnitz, F. S., Keep Your Voice Healthy: Guide to the Intelligent Use and Care of the Speaking and Singing Voice, 1495
Brown, V. E., Synopsis of Medical Parasitology, 1595
Burnet, M., Natural History of Infectious Disease, 1062
Burns
On Burns, [Womack] 526
Buros, O. K., editor, Fourth Mental Measurements Yearbook, 1228
Byrd, O. E., Textbook of College Hygiene, also Teacher's Manual, 1492
Cancer: See also Tumors
Advances in Cancer Research, Volume I, [Greenstein & Haddow] 604
Cardiology: See Heart
Cardiovascular System: See Blood Vessels; Heart
Cattell, R. B., and Warren, K. W., Surgery of the Pancreas, 988
Cauda Equina
Sacral Nerve-Root Cysts: Another Cause of the Sciatic or Cauda Equina Syndrome, [Tarlov] 604
Cawley, C. C., Fool's Haven, 1411
Cells: See Cytology
Chaoul, H., and Wachsmann, F., Die Nahbestrahlung, 1595
Chemistry: See also Biochemistry; Pharmacy
Chemistry of Carbon Compounds: Modern Comprehensive Treatise, Volume II, Part A: Alicyclic Compounds, [Rodd] 773
Elsevier's Encyclopaedia of Organic Chemistry, Series III, 1062
Encyclopedia of Chemical Technology, Volume 10, [Kirk & Othmer] 1063
Essentials of Physiological Chemistry, [Anderson] 72
Histochemistry: Theoretical and Applied, [Pearse] 1064
Hoppe-Seyler Handbuch der physiologisch- und pathologisch- chemischen Analyse, [Lang & Lehnartz] 177
Introduction to Physiological and Pathological Chemistry, [Arnow] 1325
Standard Methods of Clinical Chemistry, Volume I, [Reiner] 1495
Chest: See Thorax
Children: See also Pediatrics
Children in Play Therapy: Key to Understanding Normal and Disturbed Emotions, [Moustakas] 1228
Clinical Approach to Children's Rorschachs, [Halpern] 1134
Fathers are Parents, Too, [English & Foster] 773
Normal Child: Some Problems of First Three Years and Their Treatment, [Illingworth] 1064
Plant Proteins in Child Feeding, [Dean] 1595
Surgery of Infancy and Childhood, [Gross] 1227
Zwang und Freiheit in der Erziehung, [Meng & others] 1412
Civil Defense
Physician in Atomic Defense, [Sears] 1135
Clark, R. L., and Cumley, R. W., compilers and editors, Book of Health: Medical Encyclopedia for Everyone, 1228
Classics in Clinical Dermatology with Biographical Sketches, [Shelley & Crissey] 773
Clinical Investigation: Manual for Practitioners and Students, [Stokes] 1133
Clinical Medicine
Ballistocardiography: Application . . . . . to Clinical Medicine, [Dock & others] 1062
Progress in Clinical Medicine, [Daley & Miller] 177
Colby, F. H., Essential Urology, 691
Coley, B. L., and Higinbotham, N. L., Tumors of Bone: Roentgenographic Atlas, 890
College: See University
Colston Research Society
Suprarenal Cortex, [Yoffey] 987
Communicable Diseases
Modern Concepts of Communicable Disease, [Greenberg & Matz] 1136
Natural History of Infectious Disease, [Burnet] 1062
Textbook for Nurses, [Bower & Pilant] 1065
Community
Individual and Community Health, [Stiles] 1140
School Nursing in the Community Program, [Swanson] 1065
Conquest of Plague: Study of the Evolution of Epidemiology, [Hirst] 1595
Constitution
Vegetative Konstitutionstherapie, [Hauswirth] 1595
Contact Dermatitis, [Waldbott] 891
Cookery
Low Sodium Cook Book, [Payne & Callahan] 1137
Copying and Duplicating Medical Subjects and Radiographs, [Gibson] 1412
Cornell Conferences on Therapy, [Gold] 1065
Crime Investigation: Physical Evidence and the Police Laboratory, [Kirk] 605
Cutting, W. C., and Newman, H. W., editors: Annual Review of Medicine, Volume 4, 891
Cyclopedia: See Encyclopedia
Cytology: See also Histology
Radiations and Living Cells, [Spear] 73
Daley, R., and Miller, H., Progress in Clinical Medicine, 177
Davis, D. M., Mechanisms of Urologic Disease, 1064
Dean, R. F. A., Plant Proteins in Child Feeding, 1595
Deitrick, J. E., and Berson, R. C., Medical Schools in the United States in Mid-Century, 1325
DePalma, A. F., editor, Clinical Orthopaedics, Number One, 889
Dermatology
Atlas of Regional Dermatology, [Stratton] 1409
Classics in Clinical Dermatology with Biographical Sketches, [Shelley & Crissey] 773
Contact Dermatitis, [Waldbott] 891
Dermatologic Formulary, [Pascher] 1410
Dermatology in General Practice, [Swartz] 1409
Emotional Factors in Skin Disease, [Wittkower & Russell] 1133
Derner, G. F., Aspects of the Psychology of the Tuberculous, 1139
Diabetes Mellitus
Action of Insulin, [Haugaard & Marsh] 1062
Diabetic Neuropathies, [Goodman & others] 1492

153
53

Book Reviews—Continued
Diagnosis
Clinical Investigation: Manual for Practitioners and Students, [Stokes] 1133
Ophthalmologic Diagnosis, [Haessler] 1062
Dictionary: See also Encyclopedia
Stedman's Medical Dictionary, [Taylor] 1412
Diet: See also Food; Nutrition; Vitamins
Low Sodium Cook Book . . . . including Low Fat, Low Cholesterol Diet, [Payne & Callahan] 1137
Nutrition and Diet in Health and Disease, [McLester & Darby] 987
Digestive System
Diseases of the Digestive System, [Portis] 1063
Directory
United States Government Manual, 1953-1954, 1326
Discipline
Zwang und Freiheit in der Erziehung, [Meng & others] 1412
Disease: See also Diagnosis; Pathology; Therapeutics
Diseases of Children, [Monrieff & Evans] 890
Fundamentals of Disease: Textbook . . . . for Nurses, [von Haam] 1135
Stress and Disease, [Wolff] 891
Dock, W., Mandelbaum, H., and Mandelbaum, R. A., Ballistocardiography, 1062
Doctors: See Physicians
von Domarus, A., Manual práctico de medicina interna (compendio de patología y clínica médicas), 772
Drea, W. F., and Andrejew, A., Metabolism of Tubercle Bacillus, 989
Dreams
Die Wissenschaft vom Traum, [v. Siebenthal] 1063
Drugs: See Pharmacopeia; Pharmacy
Dunlop, D. M., Davidson, L. S. P., and McNee, J., editors, Textbook of Medical Treatment by Various Authors, 1493
Dunphy, J. E., and Botsford, T. W., Physical Examination on the Surgical Patient, 73
Duplication
Copying and Dulicating Medical Subjects and Radiographs, [Gibson & Creer] 1412
Eccles, J. C., Neurophysiological Basis of Mind: Principles of Neurophysiology, 989
Education, Medical
Medical Education Today: Its Aims, Problems and Trends, [Hinsey] 1325
Survey of Medical Education: Medical Schools in the United States in the Mid-Century, [Deitrick & Berson] 1325
Electricity
Nervous Transmission, [Tasaki] 890
Translation of Luigi Galvani's De viribus electricatitis in motu musculari commentarius, [Green] 989
Elsevier's Encyclopaedia of Organic Chemistry, Series III, [Radt] 1062
Emotions
Children in Play Therapy: Key to Understanding Normal and Disturbed Emotions, [Moustakas] 1228
Emotional Factors in Skin Disease, [Wittkower & Russell] 1133
Emphysema
Chronic Pulmonary Emphysema, [Segal & Dulfano] 1135
Encyclopedia: See also Dictionary
Book of Health: Medical Encyclopedia for Everyone, [Clark & Cumley] 1228
Elsevier's Encyclopedia of Organic Chemistry, Series III, [Radt] 1062
Encyclopedia of Chemical Technology, Volume 10, [Kirk & Othmer] 1063
Endocrinology
Endocrinology in Clinical Practice, [Gordon & Lisser] 1134
Recent Progress in Hormone Research: Proceedings of the Laurentian Hormone Conference, Volume VIII, [Pincus] 1140
Vitamins and Hormones: Advances in Research Applications, Volume X, [Harris & others] 526
English, O. S., and Foster, C. J., Fathers are Parents, Too, 773
Entomology
Social Insects, [Richards] 1137
Epidemiology
Conquest of Plague: Study of Evolution of Epidemiology, [Hirst] 1595
European Seminar and Lecture Course on Alcoholism, [WHO] 1492
Exercise
Physiology of Exercise, [Morehouse & Miller] 604
Extremities: See also Orthopedics
Atlas of Surgical Exposures of Extremities, [Laufman] 772
Eyes: See Ophthalmology
Faith Healing
Fool's Haven, [Cawley] 1411
Fathers are Parents, Too, [English & Foster] 773
Femur
Slipped Capital Femoral Epiphysis, [Klein & others] 1065
Fibrocystic Disease of the Pancreas, [Bodian & others] 1133
Fiction
Fool's Haven, [Cawley] 1411
Fildes, P., and van Heyningen, W. E., editors, Nature of Virus Multiplication, 1138
Fishbein, M., editor, 1953 Medical Progress: Review of Medical Advances during 1952, 177
Food: See also Diet; Nutrition; Vitamins
Man's Foods, [Jensen] 989
Fool's Haven, [Cawley] 1411
For Girls Only: Doctor Discusses Mysteries of Womanhood, [Richardson] 987
Formulary
Dermatologic Formulary, [Pascher] 1410
Frazer, W. M., Textbook of Public Health (Formerly Hope and Stallybrass), 256
Fungi: See Mycology
Galvani, Luigi (1737-1798)
Translation of De viribus electricitatis in motu musculari commentarius, [Green] 989
Garland, H. G., and Phillips, W., editors, Medicine, Volumes I and II, 1138
Gastroenterology
Diseases of the Digestive System, [Portis] 1063
General Medical Council
British Pharmacopoeia 1953, 1063
Genetics: See Heredity
Geriatrics: See Old Age
Ghosh, B. N., Treatise on Hygiene and Public Health with Special Reference to the Tropics, 691
Gibson, L., Copying and Duplicating Medical Subjects and Radiographs, 1412
Glaucoma: Pathology and Therapy, [Weinstein] 1137
Gold, H., editor, Cornell Conferences on Therapy, 1065
Gold-Headed Cane (1827) [Macmichael] 988
Goodman, J. I., and others, Diabetic Neuropathies, 1492
Gordan, G. S., and Lisser, H., editors, Endocrinology in Clinical Practice, 1134
Grafts: See Transplantation
Gram, E., and Weber, A., Plant Diseases in Greenhouse, Nursery and Garden Crops, 1495
Great Britain
National Health Service: Guide for Practitioners, [Sorsby] 605
History of the Second World War, [MacNalty] 1493, 1596
Green, R. M., Translation of Luigi Galvani's De viribus electricitatis in motu musculari commentarius, 989
Green and Red Planet, [Strughold] 1410
Greenberg, M., and Matz, A. V., Modern Concepts of Communicable Disease, 1136
Greenhill, J. P., editor, 1952 Year Book of Obstetrics and Gynecology, 691
Greenstein, J. P., and Haddow, A., editors, Advances in Cancer Research, Volume I, 604
Gross, R. E., Surgery of Infancy and Childhood, 1227
Group Work with the Aged, [Kuble & Landau] 1494
Gynecology
1952 Year Book of Obstetrics and Gynecology (Jule-Hinkle, 1952), [Greenhill] 691
Operative Gynecology, [TeLinde] 1228
Psychosomatic Approach to Gynecology and Obstetrics, [Weneraf] 1411
Haessler, F. H., Ophthalmologic Diagnosis, 1062
Hafferl, A., Lehrbuch der topographischen Anatomie, 1326
Halpern, F., Clinical Approach to Children's Rorschachs, 1134
Ham, A. W., Histology, 773
Hand
Functional and Surgical Anatomy of the Hand, [Kaplan] 177
Handicapped
Rehabilitation of Physically Handicapped, [Kessler] 1412
Harris, R. S., Marrian, G. F., and Thimann, K. V., editors, Vitamins and Hormones: Advances in Research and Applications, Volume X, 526
Haugaard, N., and Marsh, J. B., Action of Insulin, 1062
Hauswirth, O., Vegetative Konstitutionstherapie, 1595
Haymaker, W., and others, editors, Founders of Neurology: One Hundred and Thirty-Three Biographical Sketches, 526
Health: See also Hygiene; Mental Health
Book of Health: Medical Encyclopedia for Everyone, [Clark & Cumley] 1228
Health Principles and Practice, [Langton] 1411
Individual and Community Health, [Stiles] 1140
Introduction to Public Health, [Mustard] 454
Textbook of Public Health (Formerly Hope and Stallybrass), [Frazer] 256
Treatise on Hygiene and Public Health with Special Reference to the Tropics, [Ghosh] 691
Heart
Ballistocardiogram: Dynamic Record of the Heart Beat, [Braunstein] 1409
Ballistocardiography, [Dock & others] 1062
Clinical Unipolar Electrocardiography, [Lipman & Massie] 1493
Nomenclature and Criteria for Diagnosis of Diseases of the Heart and Blood Vessels, [Pardee] 891
Hematology: See Blood
Heredity in Health and Mental Disorders: Comparative Twin Studies, [Kallmann] 1411
Hinsey, J. C., Medical Education Today: Its Aims, Problems and Trends, [Hinsey] 1325
Hirsch, E. F., Pathology in Surgery, 454
Hirsch, W., Die Ostitis deformans Paget, 1409
Hirst, L. F., Conquest of Plague: Study of Evolution of Epidemiology, 1595
Histochemistry: Theoretical and Applied, [Pearse] 1064
Histology, [Ham] 773
Elementary Pathological Histology, [Barnard] 1596
Textbook of Histology, [Nonidez & Windle] 1494
History of Medicine: See also Medical History
History of the Second World War: United Kingdom Medical Series, [MacNalty] 1493: 1596
Hoppe-Seyler Handbuch der physiologisch- und pathologisch-chemischen Analyse, [Lang & Lehnartz] 177
Hormones: See Endocrinology
Horsley, G. W., and Bigger, I. A., Operative Surgery, Volumes I and II, 1412
Hunted Heretic: Life and Death of Michael Servetus, 1511-1553, [Bainton] 1596
Hygiene: See also Health
Textbook of College Hygiene (also Teacher's Manual), [Byrd] 1492
Treatise on Hygiene and Public Health with Special Reference to the Tropics, [Ghosh] 691
Illingworth, R. S., The Normal Child: Some Problems of the First Three Years and Their Treatment, 1064
Illness: See Disease
Immunity: Hypersensitivity, Serology, [Raffel] 72
Individual and Community Health, [Stiles] 1140
Industry
Effective Use of Older Workers, [Breckinridge] 1064
Infants: See Children; Pediatrics
Infectious Diseases: See Communicable Diseases
Injuries: See Trauma
Insects: See Entomology
Insulin
Action of Insulin, [Haugaard & Marsh] 1062
Internal Medicine
Manual práctico de medicina interna (compendio de patología y clínica médicas), [von Domarus] 772
Isotopes: See also Radioactivity
Isotopic Tracers in Biochemistry and Physiology, [Sacks] 1139
Jensen, L. B., Man's Foods, 989
Johns, H. E., Physics of Radiation Therapy, 1596
Jurisprudence: See Medical Jurisprudence
Kallmann, F. J., Heredity in Health and Mental Disorder, 1411
Kane, I. J., Sectional Radiography of the Chest, 889
Kaplan, E. B., Functional and Surgical Anatomy of the Hand, 177
Karpovich, P. V., Adventures in Artificial Respiration, 987
Physiology of Muscular Activity (originally by Edward C. Schneider), 1136
Katz, L. N., and Stamler J., Experimental Atherosclerosis, 1139
Kaufmann, H. P., Arzneimittel-Synthese, 1133
Keep Your Voice Healthy, [Brodnitz] 1495
Keers, R. Y., and Rigden, B. G., Pulmonary Tuberculosis, 1136
Kerr, W. J., Gold-Headed Cane, 988
Kessler, H. H., Rehabilitation of Physically Handicapped, 1412
Kirk, P. L., Crime Investigation: Physical Evidence and the Police Laboratory, 605
Kirk, R. E., and Othmer, D. F., editors, Encyclopedia of Chemical Technology, Volume 10, 1063
Klein, A., and others, Slipped Capital Femoral Epiphysis, 1064
Kuble, S. H., and Landau, G., Group Work with Aged, 1494
Labor: See Obstetrics
Laboratory
Crime Investigation: Physical Evidence and the Police Laboratory, [Kirk] 605
Lacey, O. L., Statistical Methods in Experimentation, 890
Lang, K., and Lehnartz, E., Hoppe-Seyler Handbuch der physiologisch- und pathologisch-chemischen Analyse, 177
Lange, M., compiler, Wiederherstellungs-chirurgie und Traumatologie, 256
Langton, C. V., and Anderson, C. L., Health Principles and Practice, 1411
Laurentian Hormone Conference
Recent Progress in Hormone Research, [Pincus] 1140
Lawrence, J. S., and Francis, J., Sulphonamides and Antibiotics in Man and Animal, 1493
Leavell, H. R., and Clark, E. G., Textbook of Preventive Medicine, 72

V 15
1953

Book Reviews—Continued
Lectures: See also Waynflete Lectures
American Academy of Orthopaedic Surgeons Instructional Course Lectures, 988
European Seminar and Lecture Course on Alcoholism, [WHO] 1492
Lectures on the Scientific Basis of Medicine, Volume 1: 1951-52, [British Postgraduate Medical Federation] 454
Lehman, H. C., Age and Achievement, 1065
Levitt, W. M., Handbook of Radiotherapy, 691
Lipman, R. S., and Massie, E., Clinical Unipolar Electrocardiography, 1494
Local Analgesia: Abdominal Surgery, [Macintosh & Bryce-Smith]
Lungs
Chronic Pulmonary Emphysema, [Segal & Dulfano] 1135
Macintosh, R. R., and Bryce-Smith, R., Local Analgesia: Abdominal Surgery, 73
McLester, J. S., and Darby, W. J., Nutrition and Diet in Health and Disease, 987
Macmichael, W., Gold-Headed Cane (1827), 988
MacNalty, A. S., editor, History of the Second World War: United Kingdom Medical Series, 1493; 1596
Man's Back, [Willis] 1133
Man's Foods, [Jensen] 989
Mars
Green and Red Planet: . . . Possibility of Life on Mars, [Strughold] 1410
Mathiasen, G., editor, Criteria for Retirement: Report of National Conference on Retirement of Older Workers, 1410
May's Manual of Diseases of the Eye, [Perera] 1596
Medical Annual: See Yearbook
Medical Education: See Education, Medical
Medical History: See also Physicians, biographies
Founders of Neurology: One Hundred and Thirty-Three Biographical Sketches, [Haymaker] 526
Gold-Headed Cane, [Macmichael] 988
Medical Jurisprudence
Crime Investigation: Physical Evidence and the Police Laboratory, [Kirk] 605
Medical Statistics: See Statistics
Medicine: See also Clinical Medicine; Diagnosis; Internal Medicine; Medical History; Physicians; Socialized Medicine; Psychosomatic Medicine; Surgery
Annual Review of Medicine, Volume 4, [Cutting & Newman] 891
Atomic Medicine, [Behrens] 1495
Introduction to Medical Science, [Muller & Dawes] 1409
Lectures on Scientific Basis of Medicine, [British Postgraduate Medical Federation] 454
Medical Progress (1953): Review of Medical Advances during 1952, [Fishbein] 177
Medicine, Volumes I and II, [Garland & Phillips] 1138
Year Book of Medicine (1953-1954), [Beeson] 1493
Meng, H., and others, Zwang und Freiheit in der Erziehung, 1412
Mental Disorders
Heredity in Health and Mental Disorders, [Kallmann] 1411
Mental Health
Oxford Conference of Mental Health Research Fund: Prospects in Psychiatric Research, [Tanner] 604
Mental Measurements Yearbook, [Buros] 1228
Metabolism of the Tubercle Bacillus, [Drea & Andrejew] 989
Midwifery: See Obstetrics
Military Medicine: See War; World War II
Moncrieff, A., and Evans, P., editors, Diseases of Children, 890
Moore, M., More Clinical Sonnets, 1325
Morehouse, L. E., and Miller, A. T., Physiology of Exercise, 604
Morenz, J. L., Who Shall Survive? 1326
Moseley, H. F., Shoulder Lesions, 1136
Moss, E. S., and McQuown, A. L., Atlas of Medical Mycology, 256
Moustakas, C. E., Children in Play Therapy, 1228
Muller, G. L., and Dawes, D. E., Introduction to Medical Science, 1409
Muscles
Diseases of Muscle: Study in Pathology, [Adams & others] 1227
Physiology of Muscular Activity, [Schneider] 1136
Sehnenverletzungen und Sehnen-Muskeltransplantationen, [Witt] 989
Translation of Luigi Galvani's De viribus electricitatis in motu musculari commentarius, [Green] 989
Mustard, H. S., Introduction to Public Health, 454
Mycology
Atlas of Medical Mycology, [Moss & McQuown] 256
Myeloma
Multiple Myeloma, [Snapper & others] 1326
National Conference on Retirement of Old Workers
Criteria for Retirement, [Mathiasen] 1410
National Health Service: Guide for Practitioners, [Sorsby] 605
Natural History of Infectious Disease, [Burnet] 1062
Neoplasms: See Cancer; Tumors
Nervous System: See Neurology
Neurology
Basis of Clinical Neurology: Anatomy and Physiology of the Nervous System in Their Application to Clinical Neurology, [Brock] 454
Diabetic Neuropathies, [Goodman & others] 1492
Estudios de neurología clínica, [Barraquer Ferré] 1134
Founders of Neurology: One Hundred and Thirty-Three Biographical Sketches Prepared for the Fourth International Neurological Congress in Paris, [Haymaker] 526
Human Neuroanatomy, [Strong & Elwyn] 1138
Nervous Transmission, [Tasaki] 890
Neurophysiological Basis of Mind: Principles of Neurophysiology, [Eccles] 989
Pituitary Chromophobe Adenomas, [Nurnberger & Korey] 1140
Progress in Neurology and Psychiatry: Annual Review, [Spiegel] 1410
Sacral Nerve-Root Cysts: Another Cause of the Sciatic or Cauda Equina Syndrome, [Tarlov] 604
Sympathetic Control of Human Blood Vessels, [Barcroft & Swan] 454
Vegetative Konstitutionstherapie, [Hauswirth] 1595
New and Nonofficial Remedies
New and Nonofficial Remedies (1953), [A.M.A. Council on Pharmacy and Chemistry] 1413
Tests and Standards for New and Nonofficial Remedies, [A. M. A. Chemical Laboratory] 1326
New York Heart Association, Inc.
Nomenclature and Criteria for Diagnosis of Diseases of the Heart and Blood Vessels, 891
Nixon, W. C. W., and Hickson, E. B., Guide to Obstetrics in General Practice, 1140
Nomenclature: See Terminology
Nonidez, J. F., and Windle, W. F., Textbook of Histology, 1494
Novels: See Fiction
Nurnberger, J. I., and Korey, S. R., Pituitary Chromophobe Adenomas, 1140
Nurses and Nursing
Communicable Disease: Textbook for Nurses, [Bower & Pilant] 1065
Fundamentals of Diseases: Textbook of Pathology and Clinical Pathology for Nurses, [von Haam] 1135
History of Anesthesia: With Emphasis on Nurse Specialist, [Thatcher] 256
Introduction to Medical Science, [Muller & Dawes] 1409
Introduction to Physiological and Pathological Chemistry, [Arnow] 1325
Modern Concepts of Communicable Disease, [Greenberg & Matz] 1136
Nursing of Children, [Sellew & Pepper] 1064
School Nursing in the Community Program, [Swanson] 1065
Nutrition: See also Diet; Food; Vitamins
Man's Foods: Nutrition and Environments in Food Gathering Times and Food Producing Times, [Jensen] 989
Nutrition and Diet in Health and Disease, [McLester & Darby] 987
Plant Proteins in Child Feeding, [Dean] 1595
Obstetrics
Guide to Obstetrics in General Practice, [Nixon & Hickson] 1140
Modern Practice of Obstetrics, [Stern & Burnett] 604
1952 Year Book of Obstetrics and Gynecology (July, 1951-June, 1952), [Greenhill] 691
Psychosomatic Approach to Gynecology and Obstetrics, [Wengraf] 1411
Occupational Medicine: See Industry
Old Age
Criteria for Retirement, [Mathiasen] 1410
Effective Use of Older Workers, [Breckenridge] 1064
Group Work with the Aged, [Kubie & Landau] 1494
Operations: See Surgery
Ophthalmology
Differential Diagnosis of Common Diseases of the Eyeground, [Tower] 1063
May's Manual of Diseases of the Eye, [Perera] 1596
Ophthalmologic Diagnosis, [Haessler] 1062
Tumors of the Orbit and Allied Pseudo Tumors, [Ingalls] 889
Orthopedics
American Academy of Orthopaedic Surgeons Instructional Course Lectures, [Pease] 988
Clinical Orthopaedics. Number One, [DePalma] 889
Shoulder Lesions, [Moseley] 1136
Slipped Capital Femoral Epiphysis, [Klein & others] 1065
Ostitis deformans Paget, [Hirsch] 1409
Ostlere, G., Trichloroethylene Anesthesia, 73
Oxford Conference of Mental Health Research Fund
Prospects in Psychiatric Research, [Tanner] 604
Paget's Disease
Die Ostitis deformans Paget, [Hirsch] 1409
Pancreas
Fibrocystic Disease of the Pancreas: Congenital Disorder of Mucus Production—Mucosis, [Bodian & others] 1135
Surgery of Pancreas, [Cattell & Warren] 988
Surgery of Pancreatic Neoplasms, [Smith] 177
Parasitology
Guide to Human Parasitology, [Blacklock & Southwell] 1493
Synopsis of Medical Parasitology, [Brown] 1595
Pardee, H. E. B., Nomenclature and Criteria for Diagnosis of Diseases of the Heart and Blood Vessels, 891
Pascher, F., editor, Dermatologic Formulary, 1410
Pathology
Diseases of Muscle: Study in Pathology, [Adams & others] 1227
Elementary Pathological Histology, [Barnard] 1596
Fundamentals of Disease: Textbook of Pathology and Clinical Pathology for Nurses, [von Haam] 1135
Grundzüge der pathologischen Physiologie, [Vogt] 72
Human Blood Coagulation and Its Disorders, [Briggs & Macfarlane] 1140
Pathology in Surgery, [Hirsch] 454
Plant Diseases in Orchard, Nursery and Garden Crops, [Gram & Weber] 1495
Surgical Pathology, [Ackerman] 1494
Payne, A. S., and Callahan, D., Low Sodium Cook Book, 1137
Pearse, A. G. E., Histochemistry: Theoretical and Applied, 1064
Pease, C. N., American Academy of Orthopaedic Surgeons Instructional Course Lectures, Volume X, 988
Pediatrics: See also Children
Diseases of Children. Volumes I and II, [Moncrieff & Evans] 890
Nursing of Children, [Sellew & Pepper] 1064
Surgery of Infancy and Childhood: Its Principles and Techniques, [Gross] 1227
Peptic Ulcer: Pain Patterns, Diagnosis and Medical Treatment, [Smith] 1492
Perera, C. A., May's Manual of Diseases of the Eye, 1596
Personality
Clinical Approach to Children's Rorschachs, [Halpern] 1134
Pesticides
Toxic Hazards of Certain Pesticides to Man, [Barnes] 889
Pharmacopeia: See Pharmacy
Pharmacy: See also Chemistry
Arzneimittel-Synthese, [Kaufmann] 1133
Dermatologic Formulary, [Pascher] 1410
New and Nonofficial Remedies, [A. M. A.] 1413
British Pharmacopoeia, 1953, [General Medical Council] 1063
Sulphonamides and Antibiotics in Man and Animals, [Lawrence & Francis] 1493
Phelps, A. E., Your Arthritis: What You Can Do About It, 256
Photography
Copying and Duplicating Medical Subjects and Radiographs, [Gibson] 1412
Physical Examination on the Surgical Patient, [Dunphy & Botsford] 73
Physicians: See also Medicine; Surgery
biographies: Classics in Clinical Dermatology with Biographical Sketches, [Shelley & Crissey] 773
biographies: Founders of Neurology: One Hundred and Thirty-Three Biographical Sketches, [Haymaker] 526
biographies, Hunted Heretic: Life and Death of Michael Servetus, 1511-1553, [Bainton] 1596
biographies: Rudolph Virchow, [Ackerknecht] 1410
Physician in Atomic Defense, [Sears] 1135
Physics of Radiation Therapy, [Johns] 1596
Physiological Chemistry: See Chemistry
Physiology: See also Anatomy
General Physiology, [Scheer] 73
Green and Red Planet: Physiological Study of Possibility of Life on Mars, [Strughold] 1410
Isotopic Tracers in Biochemistry and Physiology, [Sacks] 1139
Physiology of Exercise, [Morehouse & Miller] 604
Physiology of Muscular Activity, [Schneider] 1136
Pincus, G., editor, Recent Progress in Hormone Research; Proceedings of Laurentian Hormone Conference, 1140
Pitkin, G. P., Conduction Anesthesia, 773
Pituitary Chromophobe Adenomas, [Nurnberger & Korey] 1140
Plague
Conquest of Plague: Study of Evolution of Epidemiology, [Hirst] 1595

153
53

Book Reviews—Continued
Planets: See Mars
Plants
Plant Diseases in Orchard, Nursery and Garden Crops, [Gam & Weber] 1495
Plant Proteins in Child Feeding, [Dean] 1595
Play
Children in Play Therapy, [Moustakas] 1228
Poetry
More Clinical Sonnets, [Moore] 1325
Poisoning: See Toxicology
Police
Crime Investigation: Physical Evidence and the Police Laboratory, [Kirk] 605
Poppel, M. H., Jacobson, H. G. and Smith, R. W., Roentgen Aspects of the Papilla and Ampulla of Vater, 891
Portis, S. A., editor, Diseases of Digestive System, 1063
Preventive Medicine
Textbook of Preventive Medicine, [Leavell & Clark] 72
Proteins
Plant Proteins in Child Feeding, [Dean] 1595
Psychiatry: See also Mental Health
Die Wissenschaft vom Traum, [v. Siebenthal] 1063
Heredity in Health and Mental Disorder: Principles of Psychiatric Genetics . . . Comparative Twin Studies, [Kallmann] 1411
Practice of Psychiatry, [Sadler] 772
Progress in Neurology and Psychiatry: Annual Review, [Spiegel] 1410
Prospects in Psychiatric Research, [Tanner] 604
Psychology
Age and Achievement, [Lehman] 1065
Aspects of Psychology of the Tuberculous, [Derner] 1139
Clinical Approach to Children's Rorschachs, [Halpern] 1134
Fourth Mental Measurements Yearbook, [Buros] 1228
Psychosomatic Medicine
Psychosomatic Approach to Gynecology and Obstetrics, [Wengraf] 1411
Stress and Disease, [Wolff] 891
Psychotherapy
Who Shall Survive? Foundations of Sociometry, Group Psychotherapy and Sociodrama, [Moreno] 1326
Public Health: See Health
Radiations and Living Cells, [Spear], 73
Radioactivity
Künstliche radioaktive Isotope in Physiologie, Diagnostik und Therapie, [Abbatt & others] 73
Radiology: See also Roentgenology
Copying and Duplicating Medical Subjects and Radiographs, [Gibson] 1412
Handbook of Radiotherapy, [Levitt] 691
Physics of Radiation Therapy, [Johns] 1596
Radt, F., editor, Elsevier's Encyclopaedia of Organic Chemistry, 1062
Raffel, S., Immunity: Hypersensitivity, Serology, 72
Recipes: See Cookery
Rehabilitation of Physically Handicapped, [Kessler] 1412
Reiner, M., Standard Methods of Clinical Chemistry, Volume I, 1495
Respiration
Adventures in Artificial Respiration, [Karpovich] 987
Retirement
Criteria for Retirement: Report of National Conference on Retirement of Older Workers, [Mathiasen] 1410
Richards, O. W., Social Insects, 1137
Richardson, F. H., For Girls Only, 987
Rodd, E. H., editor, Chemistry of Carbon Compounds: Modern Comprehensive Treatise, Volume II, Part A: Alicyclic Compounds, 773
Roentgenology: See also Radiology
Die Nahbestrahlung, [Chaoul & Wachsmann] 1595
Die Wirbelsäulentuberkulose und ihre Differentialdiagnose, [Brocher] 1139
Roentgen Aspects of the Papilla and Ampulla of Vater, [Poppell & others] 891
Sectional Radiography of the Chest, [Kane] 889
Tumors of Bone: Roentgenographic Atlas, [Coley & Higinbotham] 890
Rorschach Test
Clinical Approach to Children's Rorschachs, [Halpern] 1134
Rose and Carless' Manual of Surgery, [Wakeley & others] 1137
Sacks, J., Isotopic Tracers in Biochemistry and Physiology, 1139
Sacral Nerve-Root Cysts: Another Cause of the Sciatic or Cauda Equina Syndrome, [Tarlov] 604
Sadler, W. S., Practice of Psychiatry, 772
Salt Free Diet: See Diet
Scheer, B. T., General Physiology, 73
Schneider, E. C., Physiology of Muscular Activity, 1136
Schools, Medical: See Education, Medical
Schwiegk, H., editor, Künstliche radioaktive Isotope in Physiologie, Diagnostik und Therapie, 73
Sciatica
Sacral Nerve-Root Cysts: Another Cause of the Sciatic or Cauda Equina Syndrome, [Tarlov] 604
Scars, T. F., Physician in Atomic Defense, 1135
Segal, M. S., and Dulfano, M. J., Chronic Pulmonary Emphysema, 1135
Sella Turcica
Pituitary Chromophobe Adenomas; . . . Clinical Study of the Sellar Syndrome, [Nurnberger & Korey] 1140
Sellew, G., and Pepper, M. F., Nursing of Children, 1064
Semon, H. C. G., Atlas of Commoner Skin Diseases, 1410
Servetus, Michael (1511-1553)
Hunted Heretic: Life and Death of Michael Servetus, 1511-1553, [Bainton] 1596
Sex
For Girls Only: The Doctor Discusses the Mysteries of Womanhood, [Richardson] 987
Shelley, W. B., and Crissey, J. T., Classics in Clinical Dermatology with Biographical Sketches, 773
Shoulder Lesions, [Moseley] 1136
Sickness: See Disease
v. Siebenthal, W., Die Wissenschaft vom Traum, 1063
Skin: See Dermatology
Slipped Capital Femoral Epiphysis, [Klein & others] 1065
Smith, L. A., Peptic Ulcer: Pain Patterns, Diagnosis and Medical Treatment, 1492
Smith, R., Surgery of Pancreatic Neoplasms, 177
Snapper, I., Turner, L. B., and Moscovitz, H. L., Multiple Myeloma, 1326
Social Insects, [Richards] 1137
Social Work
Group Work with the Aged, [Kuble & Landau] 1494
Socialized Medicine
National Health Service: Guide for Practitioners, [Sorsby] 605
Society for General Microbiology
Nature of Virus Multiplication: Second Symposium . . . Held at Oxford University, April 1952, [Fildes & van Heyningen] 1138
Sociometry
Who Shall Survive? [Moreno] 1326
Sonnets: See Poetry
Sorsby, M., editor, National Health Service: Guide for Practitioners, 605
Southwood, L. L., editor, Conduction Anesthesia (by G. P. Pitkin) 773
Space Travel
Green and Red Planet, [Strughold] 1410
Spear, F. G., Radiations and Living Cells, 73
Spiegel, E. A., editor, Progress in Neurology and Psychiatry: Annual Review, 1410
Spine: See also Back
Die Wirbelsäulentuberkulose und ihre Differential diagnose, [Brocher] 1139
Standard Methods of Clinical Chemistry, [Reiner] 1495
Statistics
Statistical Methods in Experimentation: An Introduction, [Lacey] 890
Stedman's Medical Dictionary, [Taylor] 1412
Stern, D. M., and Burnett, C. W., Modern Practice of Obstetrics, 604
Stiles, W. W., Individual and Community Health, 1140
Stokes, E. H., Clinical Investigation: Manual for Practitioners and Students, 1133
Stories: See Fiction
Stratton, E. K., Atlas of Regional Dermatology, 1409
Stress and Disease, [Wolff] 891
Strong, O. S., and Elwyn, A., Human Neuroanatomy, 1138
Strughold, H., Green and Red Planet, 1410
Sulphonamides and Antibiotics in Man and Animals, [Lawrence & Francis] 1493
Suprarenals: See Adrenals
Surgery
Atlas of Surgical Exposures of the Extremities, [Banks & Laufman] 772
Functional and Surgical Anatomy of the Hand, [Kaplan] 177
Local Analgesia: Abdominal Surgery, [Macintosh & Bryce-Smith] 73
Operative Gynecology, [TeLinde] 1228
Operative Surgery, [Horsley & Bigger] 1412
Pathology in Surgery, [Hirsch] 454
Physical Examination on Surgical Patient, [Dunphy & Botsford] 73
Rose and Carless' Manual of Surgery, [Wakeley & others] 1137
Surgery of Infancy and Childhood, [Gross] 1227
Surgery of the Pancreas, [Cattell & Warren] 988
Surgical Forum: 1952, [Wangensteen] 1134
Surgical Pathology, [Ackerman] 1494
Thoracic Surgical Management, [Belcher & Grant] 526
Wiederherstellungschirurgie und Traumatologie, [Lange] 256
Survey of Medical Education
Medical Schools in the United States in Mid-Century, [Deitrick & Berson] 1325
Swanson, M., School Nursing in the Community Program, 1065
Swartz, J. H., Dermatology in General Practice, 1409
Sympathetic Control of Human Blood Vessels, [Barcroft & Swan] 454
Tanner, J. M., editor, Prospects in Psychiatric Research, 604
Tarlov, I. M., Sacral Nerve-Root Cysts: Another Cause of the Sciatic or Cauda Equina Syndrome, 604
Tasaki, I., Nervous Transmission, 890
Taylor, N. B., editor, Stedman's Medical Dictionary, 1412
TeLinde, R. W., Operative Gynecology, 1228
Tendons
Sehnenverletzungen und Sehnen-Muskeltransplantationen, [Witt] 989
Terminology
Nomenclature and Criteria for Diagnosis of Diseases of the Heart and Blood Vessels, [Pardee] 891
Tests and Standards for New and Nonofficial Remedies, [A.M.A. Chemical Laboratory] 1326
Thatcher, V. S., History of Anesthesia: With Emphasis on the Nurse Specialist, 256
Therapeutics: See also Pharmacy
Cornell Conferences on Therapy, [Gold] 1065
Textbook of Medical Treatment by Various Authors, [Dunlop & others] 1493
Thorax
Sectional Radiography of the Chest, [Kane] 889
Thoracic Surgical Management, [Belcher & Grant] 526
Tower, P., Differential Diagnosis of Common Diseases of the Eyeground, 1063
Toxicology
Aviation Toxicology, [Aero Medical Association] 1134
Toxic Hazards of Certain Pesticides to Man, [Barnes] 889
Tracers
Isotopic Tracers in Biochemistry and Physiology, [Sacks] 1139
Transplantation
Sehnenverletzungen und Sehnen-Muskeltransplantationen, [Witt] 989
Trauma: See also War
Wiederherstellungschirurgie und Traumatologie, [Lange] 256
Treatment: See Therapeutics
Trichlorethylene Anaesthesia, [Ostlere] 73
Tropical Medicine
Clinical Tropical Disease, [Adams & Maegraith] 1413
Treatise on Hygiene and Public Health with Special Reference to the Tropics, [Ghosh] 691
Tubercle Bacillus
Metabolism of the Tubercle Bacillus, [Drea & Andrejew] 989
Tuberculosis
Aspects of Psychology of the Tuberculous, [Derner] 1139
Die Wirbelsäulentuberkulose und ihre Differentialdiagnose, [Brocher] 1139
Pulmonary Tuberculosis: Handbook for Students and Practitioners, [Keers & Rigden] 1136
Tumors: See also Cancer
Multiple Myeloma, [Snapper & others] 1326
Pituitary Chromophobe Adenomas, [Nurnberger & Korey] 1140
Surgery of Pancreatic Neoplasms, [Smith] 177
Tumors of Bone: Roentgenographic Atlas, [Coley & Higinbotham] 890
Twins
Heredity in Health and Mental Disorder, [Kallmann] 1411
United Kingdom: See Great Britain
United States Government Organization Manual 1953-54, 1326
University of California
Gold-Headed Cane, [Macmichael] 988
Urology
Essential Urology, [Colby] 691
Mechanisms of Urologic Disease, [Davis] 1064
Vater's Ampulla
Roentgen Aspects of the Papilla and Ampulla of Vater, [Poppel & others] 891
Virchow, Rudolf (1821-1902)
Rudolf Virchow: Doctor, Statesman, Anthropologist, [Ackerknecht] 1410
Viruses
Nature of Virus Multiplication, [Fildes & van Heyningen] 1138
Vision: See Ophthalmology
Vitamins
Vitamins and Hormones: Advances in Research and Applications. Vol. X, [Harris & others] 526
Vogt, H., Grundzüge der pathologischen Physiologie, 72
Voice
Keep Your Voice Healthy: Guide to Intelligent Use and Care of Speaking and Singing Voice, [Brodnitz] 1495
von Haam, E., Fundamentals of Diseases, 1135
WHO: See World Health Organization
Wakeley, C., and others, Rose and Carless' Manual of Surgery, 1137
Waldbott, G. L., Contact Dermatitis, 891
Wangensteen, O. H., Surgical Forum, 1134

V 15
1953

Book Reviews—Continued
War: See also World War II
Physician in Atomic Defense, [Sear] 1135
Waynflete Lectures
Neurophysiological Basis of Mind: Principles of Neurophysiology, [Eccles] 989
Weinstein, P., Glaucoma: Pathology and Therapy, 1137
Wengraf, F., Psychosomatic Approach to Gynecology and Obstetrics, 1411
William Hodson Community Center
Group Work with the Aged, [Kuble & Landau] 1494
Willis, T. A., Man's Back, 1133
Wittkower, E., and Russell, B., Emotional Factors in Skin Disease, 1133
Who Shall Survive? [Moreno] 1326
Wolff, H. G., Stress and Disease, 891
Womack, N. A., compiler and editor, On Burns, 526
World Health Organization
Toxic Hazards of Certain Pesticides to Man, [Barnes] 889
World War II
History of the Second World War: United Kingdom Medical Serles, [MacNalty] 1493; 1596
X-Rays: See Roentgenology
Yearbook
Annual Review of Medicine, Volume 4, [Cutting & Newman] 891
Fourth Mental Measurements Yearbook, [Buros] 1228
1953 Medical Progress: Review of Medical Advances during 1952, [Fishbein] 177
Progress in Neurology and Psychiatry: Annual Review, [Spiegel] 1410
Year Book of Medicine (1953-1954), [Beeson] 1493
Yoffey, J. M., editor, The Suprarenal Cortex, 987
Your Arthritis: What You Can Do About It, [Phelps] 256

C

CABLE
stainless steel, to repair ruptured patellar tendon [Chandler] *1093
CADAVERS: See Autopsies
CAISSON DISEASE
treatment, 1006—ab
CALCIUM
in Blood: See Blood
metabolism in paraplegia, [O'Connell & Gardner] *709
treatment for uterine inertia, 1141
CALCULATORS
for applying Ogino-Knaus theory, (Council report) *32
CALCULI: See Gallbladder; Kidneys; Liver
CALF: See Legs
CALIFORNIA: See Los Angeles: San Francisco University of: See University
CAMERA: See Photography
CANADA
approved medical schools in, *116; *120; (descriptive list) *146
approved school of basic sciences in, *147
CANCER: See also under name of organ and region affected
American Cancer Society, meeting in New York, 867
bequests, Ark., 1454
cell types in bronchogenic carcinoma, [Moersch] 243—ab
cells in bone marrow, [Kleimans] 1130—ab
conference, (Mich.) 649; (R. I.) 1186
Conference (2nd) on Steroids and Cancer, (proceedings) 961
control, general practitioner and lay education in, British, questionnaire, 1377
control, notification of certain forms, Sweden, 49
control program, Dr. Rector retires from, Mass., 436
control, propaganda and general practitioners, London, 234
control, 2,111 examinations to detect analyzed and evaluated, [Day] 57—ab
Detection: See Cancer control
diagnosis, Boden test, 1560
diagnosis (differential) [Hoffman] 753—ab
diagnosis, Dr. Wermer's statement before U. S. House committee, 731
diagnosis, extemporaneous cytodiagnosis, [Cassella] 1225—ab
diagnosis, seminar in cytodiagnosis, Florida, 1102
diagnosis, West-Hilliard blood test, 1229
diagnostic clinic at Chanute, Kan., 221
education, Central Health Services Council, annual report, London, 662
etiology, filtrable agent causing mouse salivary gland carcinoma, 150—E
etiology, rats injected with carcinogenic quinones from beetles, [Spies] *189; *190
etiology: smoke, London, 1059
fellowships program by American Cancer Society, 223
"field cancerization" in oral stratified squamous epithelium, [Slaughter] 1480—ab
hereditary factors in development, Paris, 664
in children: parotid gland, [Salce] 1320—ab
in families of children with leukemia, [Amiotti] 1324—ab
in twins: thyroid, 608
Institutes, Kansas, 1184
International Cancer Congress (sixth), 1954, 1292
laboratory to memorialize Senator Taft, Ohio, 1291
lectures, (Chicago) 648; (Okla.) 1104; (N. Y.) 1457
meeting on, N.Y., 1558
metastases (cardiac), incidence; clinical signs, [Bisel & others] *712
metastases from breast, [Hoffert] 1121—ab
metastases from breast to lung, [Scoll] 1584—ab
metastases (skeletal), surgery for, [Stein] 883—ab
mortality trends, 904—ab
multiple, [Arenas] 1590—ab
multiple, of breast, [Reese] 67—ab
National Advisory Cancer Council, 580
nostrum, Koch's, 647—E; 665—BI
nostrums and quackery, exposed by A.M.A. statement by Dr. Wermer, 731
patients, what Philadelphia physicians tell them, [Fitts & Ravdin] *901; [Bowen] 1570—C
precancerous keratosis of larynx [Putney] 978—ab
Prevention: See Cancer control
research, Damon Runyon Memorial Fund grants for, 1106; 1292
research, Dr. Wermer's statement before U. S. House Committee, 731
research, grants by American Cancer Society, 489
research laboratories (new,) of Imperial Cancer Research Fund, 1568
research, present status, London, 233
research theme of second A.M.A. telecast Nov. 5, 858
teaching clinics, Wis., 738
teaching day, N. Y., 963
treatment, Dr. Wermer's statement before U. S. House Committee, 731
treatment of malignant effusions with radioactive gold, [Seamen & others] *630; [Walter] 1060—ab
trust fund at U. of Chicago, 153
Warning Shadow (film review), 1573
CANICOLA Fever: See Leptospirosis
CANDIDA: See Monilia
CANNED Products for Infants: See Infants, feeding
CAPILLARIES
microscopy of skin diseases, Norway, 1471
CARAT: See Pinta
CARBACRYLAMINE RESINS
treatment of hypertension, [Gill] 1205—ab
CARBACRYLIC RESINS
quinine, N.N.R., (description) 1362; (Squibb) 1362
CARBO-FUNG
treatment of ringworm of scalp, [Henricke] 1380—C
CARBO-RESIN: See Carbacrylamine Resins
CARBOHYDRATES: See also Glucose: Sugar
metabolism (abnormal), screening procedure for diagnosis, [McLoughlin & others] *182
metabolism, interdependence of stress and adrenal cortex in, [Burns] 979—ab
CARBOLIC ACID: See Phenol
CARBOMYCIN (Magnamycin)
experiences with, [Hewitt] 1053—ab
CARBON DIOXIDE
gas, cause of death in silo, 893
inhalation in muscular rigidity, (correction) 225; [Leavitt] 509—C
Research Assn. to succeed Committee on Carbon Dioxide Research, 572
CARBON TETRACHLORIDE
hazardous dry cleaning agents, 1232
odor, in drafting room, 1251
CARBUNCLE
Malignant: See Anthrax
CARCINOGENESIS: See Cancer etiology
CARCINOMA: See Cancer
CARDIAC: See Heart
Muscle: See Myocardium
CARDIOLOGY: See Heart
CARDIOSPASM: See Stomach
CARDIOVASCULAR DISEASE: See also Blood Vessels disease; Heart disease
blood coagulation in, [Weis] 70—ab
cause of death in physicians, [Poynton] 1379—C
census, Sweden, 584
epinephrine and, 1496
Hypertensive: See Blood Pressure, High
lectures, Conn., 962
research, Ga., 1183
symposium on, Vt., 738
treatment, ligate inferior vena cava, [Bracci] 432—ab
treatment, liver extract and vitamin B_{12} in children, [Masi] 1129—ab
CARDIOVASCULAR SYSTEM: See Arteries; Blood Vessels; Heart; Vasomotor System; Veins
CARDITIS: See Heart Inflammation
CARELLI'S technique: peritoneal oxygen insufflation, [Ritter] 244—ab
CARIES: See Teeth, caries
CAROTID ARTERY: See Arteries
CAROTID SINUS
denervation, treatment of myasthenia, [Thevenard] 170—ab
reflex (hyperactive) of cardioinhibitory type, [Soloff] 1205—ab
CARREL, ALEXIS (1873-1944)
Georgetown U. receives his manuscript collection, D. C., 734
CARRIERS: See Dysentery; Streptococcus
CARROTS
diced, Comstock Brand Dietetic Pack, 1099
diced, Matchless Brand Dietetic Pack, 217
Overland Brand Dietetic Pack, 1099
CARS: See Automobiles
CASE
Finding: See Diabetes Mellitus; Tuberculosis
CAST
melmac plaster, allergic contact dermatitis from, [Conrad & Ford] *557
CASTLETON, K. B., speaks his mind on A.M.A. policy, 151
CASUALTIES: See also Accidents; Automobiles, accidents; Disasters; Korean War
atomic bomb, of Nagasaki, [Shirabe] 1482—ab
evacuation and care of in aircraft (hospital plane; helicopters), [White & Merkle] *20
medical, in World War II, 46
CATS: See Cats
CATARACT
causes of blindness in England, 1469
rubellar embryopathy, [Malbran] 886—ab
CATASTROPHIES: See Disasters
CATHARTICS
esophageal obstruction from Serutan; liquid Taka-diastase relieves, [Johnson] 235—C
CATHETERIZATION: See Heart, catheterization; Veins, hepatic
CATHETERS
polyethylene, simple coupling device for, [Alman & Whoriskey] *562
CATS
scratch disease, [Tonge] 1323—ab
scratch disease and Parinaud's conjunctivitis, [van Veelen] 453—ab
CATTLE
toxoplasmosis, 565—ab
trace element supplements dairy ration to prevent brucellosis, (Council article), [Berman] *643
vaccination, brucellosis in 2 veterinarians from strain 19 vaccine, [Spink & Thompson] *1162; 1176—E
CAUSALGIA
treatment, sympathectomy, [Barnes] 1220—ab
CAVAL Veins: See Vena Cava
CAVITIES: See Lungs; Teeth caries
CELIAC DISEASE
treatment, corticotropin, [Meyer] 248—ab
CELLS: See also Blood cells; Cancer; Cytology; Tissues
Anitschkow's in rheumatic granuloma, [von Albertini] 1491—ab
Chromaffin: See Pheochromocytoma
extemporaneous cytodiagnosis, [Castelain] 1225—ab
CEMENT
floors, conducive to rheumatoid conditions? 1414
vs. wooden floors in gymnasium, 893
CENTRAL HEALTH SERVICES COUNCIL
annual report of 1952, London, 662
regional planning of diabetic services, London, 661
CEREBRAL: See Brain
Palsy: See Paralysis, cerebral
CEREBROSPINAL FLUID
diverted into urinary tract in hydrocephalus, [Matson] 1483—ab
Hyperalbuminosis of: See Guillain-Barré Syndrome
streptomycin in, of patients with tuberculous meningitis, [Pani] 688—ab
tests for reagin after treating neurosyphilis, [Thomas] *718
CEREBROSPINAL MENINGITIS: See Meningitis
CEREBROSPINAL SYPHILIS: See Neurosyphilis
CEREBROVASCULAR Accidents, etc.: See Brain
CEREBRUM: See Brain
CER-O-CILLIN Potassium: See Penicillin O
CERTIFICATION: See American Board
CERVIX Uteri: See Uterus
CESAREAN SECTION
combined anesthesia with curare in, [Bergquist] 1129—ab
in diabetic, [Tolstol & others] *1000
indications for, Finland, 1377
CEVITAMIC ACID: See Acid, ascorbic
CHAGAS Disease: See Trypanosomiasis
CHAIR: See Wheelchair
CHAIRMAN'S Address: See American Medical Association, Section on .....
CHARACTERISTICS: See Personality
CHARCOT'S JOINTS
caused by insensitivity to pain, [Petrie] 1221—ab
disintegration; treatment, 991

CHARCOT-MARIE-TOOTH Disease: See Atrophy, muscular
CHARITY: See Medically Indigent
CHEESE
Heinz Junior Cheese and Macaroni, 1521
Heinz Strained Cheese and Rice, 1521
CHEMICAL LABORATORY of the A.M.A.: See American Medical Association
CHEMICALS
disease is chemical and chemically correctable, [Spies] *185
toxicity, perspective vs. caprice in evaluating, [Seevers] *1329
CHEMISTRY
A. M. A. Council on Pharmacy and Chemistry: See American Medical Association
CHEMOTHERAPY: See also under specific substances as Nitrogen Mustard
of primary exudative pleurisy, Finland, 1377
of tuberculous meningitis and miliary tuberculosis, [USPHS] 760—ab
CHEST: See Thorax
CHICAGO
natal day deaths, long-neglected field of infant mortality, [Bundesen] *466
CHICKENS: See Eggs
CHILD SPECIALISTS: See Pediatricians
CHILDBIRTH: See Labor
CHILDREN: See also Infants; Maternity; Paternity; Pediatrics; under names of specific diseases as Cancer
accidents from firearms, preventing, 1365—E
Adolescent: See Adolescence
behavior changes in subjected to tonsillectomy, 493—E
chronically ill, group therapy, [Koven] 1479—ab
Crippled: See Crippled
death (unexpected) in, and pulmonary thrombosis, [Emery] 885—ab
exceptional, 10th Governor's Conference on, Ill., 220
Frustrating Fours and the Fascinating Fives: Ages and Stages Series (film review), 1202
Growth of: See Growth
Handicapped: See Handicapped
Hospitals for: See Hospitals, children's
Kartagener's syndrome in, [Dikey] 243—ab
kwashiorkor, (Council article) [Williams] *1280
liver cell tumors in, [Christopherson] 1480—ab
nasal sinusitis in: value of roentgen therapy, 1232
National Congress for Protection of, Mexico, 1568
personality changes in, antihistaminic drugs causing, [Schaffer] 589—ab
pheochromocytoma in 9-year-old Negro boy, [Goldfarb] 1311—ab
poisoning: lead absorption from pica, [van Wisselingh] 69—ab
remote effects of obstetrical labor on, [Benaron] 1206—ab
school, preventoriums for, Paris, 664
school, what paints and crayons are safe? 455
urinary retention in, [Powell] *1341
vaccination of child with eczema, (replies), [Baldridge; Little] 694
CHILEAN
Society of Cardiology, bulletin, 1112
Society of Dietetics, anniversary, 1036
CHIROPODY: See Medicolegal Abstracts at end of letter M
CHIROPRACTIC: See Medicolegal Abstracts at end of letter M
CHLORAMPHENICOL (Chloromycetin)
intestinal antiseptics, [Poth] *1516
toxicity: acute necrosis of liver, [Salm] 1128—ab
toxicity: fatal aplastic anemia, [Koster] 888—ab
treatment, fails in infectious mononucleosis, [Walker] 587—ab
treatment of acute ulcerative colitis due to Salmonella pullorum, [Doenges] *1018
treatment of surgical infections, [Meleney & Johnson] *1256
treatment plus oxytetracycline of lesions in Letterer-Siwe disease, [Fisher] 62—ab
CHLORDANE
intoxication, [Dadey & Kammer] *723
CHLORIDES: See Ammonium Compounds; Sodium chloride; Zinc chloride
CHLORINE
solution to control bacteria count in crushed ice, 1101—E
*dd*CHLORODIPHENYLTRICHLOROETHANE: See Chlorophenophane (DDT)
CHLOROMYCETIN: See Chloramphenicol
CHLOROPHENOTHANE (DDT)
add to water supply? 1598
house sprayed with, to control leishmaniasis, Brazil, 1299
CHLOROPHYLL
deodorization and, 728—E; [Westcott; Ryan; Langley] 749—C; [Hein] 1571—C
effect on wound healing, [Lam] 1571—C
CHLOROPROCAINE Penicillin O: See Penicillin O
CHLOROQUINE
phosphate for chronic discoid lupus erythematosus, [Farber] 1580—ab
treatment of hymenolepiasis, [Basnuevo] 974—C
treatment, single intramuscular injection in malaria, [Jelliffe] 453—ab
CHLOROTRIANISENE (Tace)
treatment of prostate cancer, [Mortensen] 766—ab
CHLORPROMAZINE
new antiemetic drug, [Friend & Cummins] *480
sleep therapy induced with [Delay] 1590—ab
CHLORPROPHENPYRIDAMINE MALEATE (Chlor-Trimeton)
combined with penicillin for endocarditis in penicillin-sensitive patient, [Beck] *1170
to prevent penicillin reactions, [Rapaport & others; Luippold; Simon; Roberts] 1498
CHLORTETRACYCLINE (Aureomycin)
intestinal antiseptics, [Poth] *1516
prophylaxis of rheumatic fever, [McVay] 1402—ab
treatment, fails in infectious mononucleosis, [Walker] 587—ab
treatment of actinomycosis, [McVay] 59—ab
treatment of subacute suppurative inguinal lymphomatosis, Turkey, 877
treatment of surgical infections, [Meleney & Johnson] *1256
treatment of vaccinia in eyelids, [King & Forrest] *31
CHLOR-TRIMETON MALEATE: See Chlorpropphenpyridamine Maleate
CHOLANGIOGRAPHY: See Bile Ducts roentgen study
CHOLECYSTITIS: See Gallbladder inflammation
CHOLECYSTOGRAPHY: See Gallbladder, roentgen study
CHOLELITHIASIS: See Gallbladder, calculi
CHOLERIFORMIC SYNDROME, mechanism of development, [Poth] *1517
CHOLESTEROL
in Blood: See Blood
intimal ground substance in atherosclerosis, [Willis] 685—ab
CHOLINE: See also Acetylcholine; Succinylcholine
gluconate, N.N.R., (Chemo Puro) 727
CHOLINERGIC DRUGS
Anticholinergic: See Anticholinergic Drugs
new, for postoperative urinary retention, [Weinstein & Roberts] *268
CHOLINESTERASE
Anticholinesterase: See Anticholinesterase
CHORDOMA
of lumbar vertebra, [Baker] 62—ab
CHOREA
minor treated with combined corticotropin and cortisone, [Schwartzman] 1212—ab
CHORIANGIOMA (hydatidiform mole): See Placenta tumors
CHRISTIAN MEDICAL COUNCIL FOR OVERSEAS WORK
[Forman] 1114—C
CHRISTIAN MEDICAL RESEARCH LEAGUE
fraudulent license issued to Jacob S. Schirmer 647—E; 665—B1
CHRISTIAN-Weber Disease: See Panniculitis
CHROMAFFIN
Cell Tumor: See Pheochromocytoma
CHROMIUM
chromate hazards in industry, (Council article) [Walsh] *1305
CHROMOBLASTOMYCOSIS
13th reported case in U. S., [Barwasser] *556
CHROMOMYCOSIS: See Chromoblastomycosis
CHROMOSOMES
counting, 992
detect chromosomal sex from skin biopsy in hermaphrodites, [Moore] 65—ab
CHRONICALLY ILL: See Disease, chronic
CHRYSOTHERAPY: See Gold, radioactive
CHURCHILL, Sir WINSTON LEONARD SPENCER, 1874—
"Sunday" painter, [Leisure Corner] *508
CIGARETTES: See Tobacco
CINDERS
block for gymnasium walls, 893
CINEMA: See Moving Pictures
CINEMATOGRAPHS
high speed color, in spontaneous auricular flutter, [Prinzmetal & others] *553
CIRCLE of Willis, Aneurysm of: See Aneurysm
CIRCULATION: See Blood circulation
CIRCULATORY DISEASE: See Cardiovascular Disease
CIRCUMCISION
according to Jewish rite, 1497
CIRRHOSIS: See Liver
CITATIONS: See Prizes
CITIZENS
Advisory Commission on Medical Care of Dependents of Military Personnel, President's page, 1178
CITRUS Fruit: See Fruit
CIVILIAN DEFENSE
activities, (Council report) 841
against biological warfare agents, 859
course, Tenn., 571
director looks at the medical problem, [More] *1007
meeting, W. Va., 1558
participation in military medical affairs, (Council report) 840
CLAIMS, Forms for: See Insurance
CLAUDICATION
intermittent, controlled ergometric studies of effect of heparin on, [Simon & Wright] *98; [Collens] 1115—C; (reply) [Simon; Wright] 1115—C
of hip, 791—ab
CLEANING: See Dry Cleaning
CLEFT PALATE: See Palate
CLIMACTERIC: See Menopause
CLIMATE: See also Meteorology
heart disease and, [Mills] *910
CLIMATIC BUBO: See Lymphogranuloma, Venereal
CLINICAL
Laboratories: See Laboratories
Laboratory Technicians: See Technologists
Meeting: See American Medical Association
research, Northwest Society for, invites papers, 963
CLINICS: See also Crippled children; Deafness; Diabetes Mellitus; Dystrophy, muscular; Heart; Mental Health; Orthopedics; Tumors
American Association of Medical Clinics: group practice study, (report) 955
postgraduate television, Utah 1458
CLOTHING: See Hosiery
CLOTTING: See Blood coagulation
Intravenous: See Thrombophlebitis
CLUBFOOT: See Foot
COAGULATION: See Blood coagulation
Anticoagulants: See Anticoagulants
COBALT
bomb for Italy, 41
nitrite sodium to determine serum potassium, [Keitel & Keitel] *790
radioactive, in postoperative treatment of bronchial cancer, [Schneidrzik] 764—ab
COCCIDIOIDIN
testing with, in Philippine tuberculosis hospital, [Halde] 754—ab
COCONUT
desiccated, typhoid epidemic traced to, Australia, 162
CODE of Ethics: See Ethics, Medical
"COIN Lesions": See Lungs
COITUS: See also Contraception; Frigidity; Impotence; Impregnation; Spermatozoa
Kinsey report: anatomy of pubococcygeus muscle and sexual physiology of vagina, [Kegele] 1303—C
Kinsey report on Danish women, 1300
physiological and clinical aspects of conception, [Tyler] *1351
COLD: See also Frostbite; Ice
blood pressure reactions to, Chile, 969
storage of blood below 32° F in liquid state, [Lorant] 1577—ab
therapeutic use in sprains, 1142
therapeutic use, induced hypothermia or refrigeration differentiated from artificial hibernation, [Doglotti] 1225—ab
therapeutic use, surgery by direct vision in open heart during hypothermia, [Swan & others] *1081
COLDS: See also Hay Fever
common cold virus, London, 1038
COLITIS
amebic, granuloma of rectum simulating cancer, [Ernst] 1056—ab
staphylococcic gastroenterocolitis, [Terplan] 1481—ab
ulcerative, acute, due to Salmonella pullorum, chloramphenicol cures, [Doenges] *1018
ulcerative chronic, and acute and chronic bacillary dysentery, [Felsen & Wolarsky] *1069; [Palmer; Cheever] 1199—C
ulcerative chronic, medical treatment: ACTH, cortisone, psychotherapy, etc. [Morrison] 1580—ab
ulcerative, chronic nonspecific, Chile, 970
ulcerative: giant ulceration after corticoid therapy, [Texter] 237—ab
ulcerative, liver disease with, [Bargen] 881—ab
ulcerative, surgical management, [Bacon & Trimpi] *1249
ulcerative, what is it? [Brooke] 600—ab
COLLAPSE: See Shock
Pulmonary: See Lungs
Therapy: See Pneumothorax, Artificial; Tuberculosis of Lung
COLLECTION of Bills: See Fees
COLLEGE: See also University
Degrees: See Degrees
Education: See Education, Medical, premedical
Medical: See Schools, Medical
of General Practitioners, London, (teaching of general practice), 600; ("Research Newsletter No. 1") 1039

V 15
1953

COLLEGE—Continued
of Physicians, etc.: See International College
Students: See Students, Medical
COLLIER'S Magazine: See Journals
COLON: See also Colitis
amebic granuloma in, Brazil, 745
cancer after chronic ulcerative colitis, [Bacon & Trimpi] *1250
isoperistaltic, as substitution for esophagus, [Dogliotti] 1488—ab
megacolon, acute obstruction in, Brazil, 745
megacolon, volvulus of, Brazil, 873
roentgen examination [Hodges] *1417
roentgen examination, limitation, [Swenson & Jeffrey] *1423
surgery, resection for diverticulitis of sigmoid, [Welch] 1207—ab
surgery, type of operation for ulcerative colitis, [Bacon & Trimpi] *1249
tumors, polyps, program for detection, [Glanturco & Miller] *1429
COLOR: See also Discoloration; Dyes; Eyes, color; Stains and Staining
indicator, use in storing ampuls for spinal anesthesia, [Lewis] 50—C
Television: See Television
COLORED
Crayons: See Crayons
People: See Negroes
COLORING: See Stains and Staining
COMBAT: See World War II
COMMERCIAL SOLVENTS Award: See Prizes
COMMISSION: See also International Commission; list of Societies and Other Organizations at end of letter S
Advisory: See Citizens Advisory Commission on Chronic Illness, Dr. McCormick's statement before U. S. House Committee, 730
President's: See President's Commission
COMMISSIONS: See Armed Forces; Army, U. S.
COMMISSUROTOMY: See Aortic Valve; Mitral Valve stenosis
COMMITTEE: See also Advisory Committee; Cope Committee; list of Societies and Other Organizations at end of letter S
A. M. A.: See American Medical Association
on Accreditation of Nursing Schools, [Murdock] *1443; *1444
on Indigent Care: See American Medical Association Council on Medical Service
on Relations Between Medicine and Allied Health Agencies, statement by Dr. McCormick before U. S. House Committee, 730
to Study Essentials of Modern Medical Practice Act, created by Federation of State Medical Boards, (Bureau report) 838
COMMON COLD: See Colds
COMMUNICABLE DISEASES: See Infectious Diseases
COMMUNITY
Health Council: See Health councils
rating by physician for establishing a practice, (Council report) 236
COMPENSATION: See Wages
for Injuries, etc.: See Workmen's Compensation
of Physicians: See Fees
COMPLEMENT
fixation test in poliomyelitis, [LeBouvier] 1057—ab
fixation test in toxoplasmosis, [Roth] 1225—ab
test (Kelser's) in trypanosomiasis, Colombia, 1037
COMPOUND B: See Corticosterone
COMPOUND E: See Cortisone
COMPOUND F: See Hydrocortisone
COMPOUNDS (listed by number)
341 W, [Weinstein & Roberts] *268
2601-A, [Friend & Cummins] *480
30958, [Magee & Duong] *715
COMPRESSED Air Disease: See Caisson Disease
COMPRESSION
arthrodesis of knee using double wire and tightening lever, [Greifensteiner] 603—ab
COMSTOCK BRAND DIETETIC PACK PRODUCTS
diced carrots; cut green beans; corn, 1099
CONCEPTION: See Fertility; Impregnation; Pregnancy; Sterility
Control of: See Contraception
CONCRETE: See Cement
CONDUCT: See Behavior; Ethics, Medical
CONFERENCE: See also National Conference; under list of Societies at end of letter S
A. M. A. sponsored: See American Medical Association
on Physicians Placement Service Activities, (Council report) *1116
on regulation of diathermy equipment, 1187
on Steroids and Cancer (2nd) proceedings, 961
CONFIDENTIAL Communications: See Privileged Communications
CONGELATIO: See Frostbite
CONGO
Free State: See Belgian Congo
CONGRESS: See also International Congress; World Congress; list of Societies and Other Organizations at end of letter S
Annual Congress: See American Medical Association
French Congress of Medicine, 41
of International Association for Public Welfare, Paris, 748
U. S.: See United States Congress
U. S., legislation considered by: See Laws and Legislation, federal
CONJUNCTIVITIS
Parinaud's, and cat scratch disease, [van Veelen] 453—ab
CONSTIPATION: See Cathartics
CONSTITUTION (biologic): See also Personality; Psychosomatic Medicine
relation to blood pressure, [Russo] 1218—ab
CONSTITUTION (governmental)
U. S.: See United States
CONSULTATION
Clinic: See Heart
CONSULTING PATHOLOGIST GROUP COMMITTEE
report on transfusion accidents, London, 875
CONTACT
Dermatitis: See Dermatitis venenata
CONTAGION: See Infection
CONTAGIOUS DISEASE: See Infectious Disease
CONTAINERS: See Bottles
CONTAMINANTS: See under Bacteria; Blood Transfusion
CONTEBEN: See Amithiozone
CONTEST: See Prizes
CONTINUATION Courses: See Education, Medical, graduate
CONTRACEPTION
calculators for applying Ogino-Knaus theory, (Council report) *32
commercial contraceptives, changes in consistencies, (Council article) [Gambel] *1019
Intracervical and intrauterine devices, (Council report) 1285
CONTRACTURE: See also Cramps; Spasm
Dupuytren's, 1597
CONVALESCENCE: See Rehabilitation
CONVALESCENT
Homes: See Nursing Homes
Serum: See Serum
CONVENTION: See American Medical Association
CONVERTIN
blood coagulation studies, [Lund] 602—ab; 662; 876
CONVULSIONS: See also Eclampsia; Epilepsy
in infants, artificial hibernation for, France, 1197
in infants fed liquid SMA (Council report) 939; 1521
Therapeutic: See Electric shock treatment
COOK (W. Albert) Lecture: See Lectures
COOKING
for pleasure, (Leisure Corner) *975
CO-OPERATIVE
Medical Advertising Bureau: See American Medical Association, State Journal Advertising Bureau
COPE COMMITTEE
medical auxiliaries, London, 971
COPPER
deficiency in dogs cause of anemia, [Van Wyk] 882—ab
COR
Pulmonale: See Heart hypertrophy
CORN
Matchless Brand Dietetic Pack Golden sweet corn (cream style); also whole kernel, 645
CORNEA
band-shaped, with uveitis in child with arthritis [Davis] 1574—ab
Inflammation: See Keratitis
use of ophthalmic ointments in industrial practice, 1416
CORONARY
Arteries: See Arteries, coronary
Embolism: See Embolism
Thrombosis: See Thrombosis, coronary
CORONER SYSTEM
medicolegal experiences under, Ohio, [Landé & Boone] *179
merits of, statistical comparison with medical examiner system, [Turkel] *1086; 1100—E
CORPSE: See Autopsies
CORPUS LUTEUM
Hormone: See Progesterone
CORTICOIDS
toxicity: giant ulcer of colon, [Texter] 237—ab
CORTICOSTERONE (compound B)
effects in rheumatoid arthritis, [Clark] 979—ab
CORTICOTROPIN (ACTH)
affects nutrition process, [Spies] *193
psychological concomitants, [Rees] 1221—ab
toxicity: giant ulcer of colon, [Texter] 237—ab
Treatment: See also Celiac Disease; Colitis, ulcerative; Granuloma; Leukemia
CORTICOTROPIN (ACTH)—Continued
treatment, long-acting ACTH for asthma in children, 584; [Bergstrand] 767—ab
treatment of herpes zoster, 1415
treatment of leiodystonic syndrome, [Pock-Steen] 1593—ab
treatment or cortisone and hydrocortisone in nephrotic state, [Luetscher & others] *1236
treatment or cortisone in ragweed hay fever and ragweed asthma, 1066
treatment plus aminopterin and cortisone in acute leukemia in children, [Käss] 1224—ab
treatment plus antibiotics in overwhelming infections, [Kinsell] 684—ab
treatment plus cortisone in acquired hemolytic anemia, [Letman] 1593—ab
treatment plus cortisone in chorea minor, [Schwartzman] 1212—ab
treatment plus cortisone in lupus erythematosus, [Cohen] 1221—ab; 1467
treatment plus cortisone in periarteritis nodosa, [Canestrini] 1490—ab
treatment plus cortisone in severe fulminant viral hepatitis, [Evans] 448—ab
treatment plus cortisone in skin diseases, [King] 1403—ab
treatment plus cortisone in trichinosis, [Alvarez Buylla] 690—ab
treatment, short-term, in active rheumatic carditis, [Wilson] 1046—ab
treatment vs. sympathetic block shoulder-hand syndrome, [Steinbrocker & others] *788
CORTISONE (Compound E)
acetate (synthetic) affects nutrition process, [Spies] *193
Hydro-: See Hydrocortisone
infection encouraged by, report at symposium, Italy, 1467
International symposium on, Italy, 1467
metabolic effects, Italy, 1467
toxicity: giant ulcer of colon, [Texter] 237—ab
toxicity: perforated gastric ulcer, [Kerdasha] 1053—ab
Treatment: See also Gold dermatitis; Hodgkin's Disease; Panniculitis
treatment, caution advised in rheumatoid arthritis, London, 1301
treatment, clinical effects, Italy, 1467
treatment combined, in rheumatic disease, [Ballabio] 1491—ab
treatment, effect on incidence of rheumatic heart disease, [Johnson] 63—ab
treatment, intraperitoneal and subcutaneous compared, [Greenspan] 518—ab
treatment or corticotropin of nephrotic state, [Luetscher & others] *1236
treatment or corticotropin of ragweed hay fever and ragweed asthma, 1066
treatment plus aminopterin and corticotropin in acute leukemia in children, [Kass] 1224—ab
treatment plus antibiotics in overwhelming infections, [Kinsell] 684—ab
treatment plus corticotropin in acquired hemolytic anemia, [Letman] 1593—ab
treatment plus corticotropin in chorea minor, [Schwartzman] 1212—ab
treatment plus cortisone in lupus erythematosus, [Cohen] 1221—ab; 1467
treatment plus corticotropin in periarteritis nodosa, [Canestrini] 1490—ab
treatment plus corticotropin in skin diseases, [King] 1403—ab
treatment plus corticotropin in severe fulminant viral hepatitis, [Evans] 448—ab
treatment plus corticotropin in trichinosis, [Alvarez Buylla] 690—ab
treatment, psychological concomitants, [Rees] 1221—ab
treatment to prevent peritoneal adhesions, [Lyall] 523—ab
treatment vs. sympathetic block in shoulder-hand syndrome, [Steinbrocker & others] *788
CORYZA: See Colds
COSMETICS
A.M.A. Committee on, 4th annual report, 936
COSTS: See Economics, Medical
COUGH: See also Colds; Hemoptysis; Sputum; Whooping Cough
after-cough fainting in asthma, [Derbes] 762—ab
COUGHING Up Blood: See Hemoptysis
COUGHLIN, George G., right to deduct from income tax postgraduate expenses, (Bureau report) 837
COUMARIN: See Bishydroxycoumarin
COUNCIL: See Health council; International Council; Medical Research Council; National Council; National Research Council; National Safety Council
COUNSELING
misdirective, 4—ab
vocational, for children with cardiac disorders, N. Y., 1456
COUNTY
Health Dept.: See Health
Society: See Societies, Medical; list of Societies at end of letter S
COURSES: See Education, Medical

COURT Decision: Trial: See Medical Jurisprudence
COWPOX: See Vaccinia
COWS: See Cattle
Milk: See Milk
COXSACKIE DISEASE
virus, role in epidemic pleurodynia, [Swain] 597—ab; [Paiz] 601—ab
viruses associated with encephalitis outbreak, [Stanley] 251—ab
viruses in poliomyelitis, [Stanley] 251—ab
CRAFT
Undersea: See Submarines
CRAMPS
of leg in pregnancy; etiology; treatment, 1229
of leg in pregnancy, treatment recommended; use of quinine advisable? 992
CRANIOPAGUS
surgical separation in, [Grossman & others] *201
CRANIUM: See also Brain
surgical separation in craniopagus (Brodie twins), [Grossman & others] *201
CRAYONS
which are safe for children to use? 455
CREAM: See Cheese
CREEPING Eruption: See Larva migrans
CRETINISM
sporadic, in one of fraternal twins, [James] 1132—ab
CRIMINAL ABORTION: See Abortion
CRIPPLED: See also Handicapped; Poliomyelitis
children and adults, National Society for, annual convention, 963
children, clinics for, (Illinois) 648; (Nebraska) 1557
children, meeting on, Va., 437
CROHN'S Disease: See Ileitis, regional
CRUISE: See Travel
CRYMOTHERAPY: Cryotherapy: See Cold, therapeutic use
CRYPTOCOCCOSIS (torulosis)
pulmonary, [Stiefel] 1407—ab
CRYPTORCHISM: See Testes, undescended
CURARE
sublingual administration, [Neff] 1576—ab
combined with anesthesia in cesarean section, [Bergquist] 1129—ab
CURETTAGE
in tuberculosis of joints, [Wilkinson] 1220—ab
CURLING'S Ulcer: See Ulcers
CUSHING'S SYNDROME
diagnosis of hyperadrenocorticalism, Italy, 1468
hypopotassemia and other electrolytes in, [Sprague] 449—ab
treatment, adrenal surgery, [Poutasse] 1051—ab
treatment, bilateral adrenalectomy, 567—E
treatment, electrocoagulation of hypophysis in, [Arner] 1123—ab
treatment, hypophysectomy, [Luft] 171—ab; [Détrie] 1590—ab
CYANOCOBALAMIN (vitamin B_{12})
in blood serum in megaloblastic anemia, [Mollin] 1485—ab
research, symposium on, 960—E
treatment, large doses in discoid lupus erythematosus, [Marcus] 1050—ab
treatment, massive doses, efficacy, [Chevallier] 769—ab
treatment, massive doses in neurological conditions, [Lereboullet] 601—ab
treatment of anemia [Spies] *188; *190; *192
treatment of blood diseases, medicosurgical society discusses, Italy, 1037
treatment, massive doses in parkinsonism, 257
treatment of nutritional macrocytic anemia, [Das Gupta] 1486—ab
treatment of symptoms after gastrectomy, 1068
treatment plus liver extract and folic acid in pernicious anemia, [Canelas] 1215—ab
treatment plus liver extract in children respiratory tract and cardiovascular apparatus, [Masi] 1129—ab
vitamin B_{12} with intrinsic factor concentrate, name accepted by Council, 801
vitamin B_{12} with intrinsic factor concentrate, N. N. R., (description) 565; (Bifacton of Organon) 565
CYCLOGYL: See Cyclopentolate Hydrochloride
CYCLOPENTOLATE HYDROCHLORIDE (Cyclogyl)
name accepted by Council, 801; (correction) 1175
CYCLOTRON
new developments in radiotherapy, London, 1301
CYCRIMINE (Pagitane)
treatment of paralysis agitans, [Magee & DeJong] *715
CYST: See under names of specific organs as Esophagus; Kidneys; Lungs; Ovary; Pancreas
Hydatid: See Echinococcosis
CYTOCHROME C
therapy in aged in state hospital, [Levy] *1260
CYTODIAGNOSIS: See Cancer; Tumors
CYTOLOGY: See also Cells
Institute of, N. Y., 1184
CYTOMYCOSIS, Reticulo-endothelial: See Histoplasmosis

D

DDS: See p,p'Sulfonyldianiline
DDT: See Chlorophenothane
DABNEY'S Grip: See Pleurodynia, Epidemic
DACRYOCYSTITIS: See Lacrimal Sac
DAIRY PRODUCTS: See Cheese; Milk
DAIRY RATION: See Cattle
DAMON RUNYON Memorial Fund: See Foundations, Runyon
DANISH
women, sexual life of, 1300
DARLING'S Disease: See Histoplasmosis
DARSTINE Bromide: See Mepiperphenidol Bromide
DATES
phytobezoar from eating wild dates, Turkey, 1471
DAVIS, NATHAN SMITH (1817-1904)
silver cup given to A. M. A. by his grandchildren, 1367
DEAD BODIES
Examination: See Autopsies
DEAFNESS
amplifying stethoscopes for deafened physician, 776
clinic for hard of hearing, Calif., 1025
etiology: quinidine? 1142
etiology: streptomycin, [Winston] 752—ab
keratitis (nonsyphilitic interstitial) with, [Oliner] 450—ab
meetings for parents of preschool deaf children, 649
perceptive, from tetanus antitoxin, [Berger] 165—ab
research, Chandler Ford Fund for, Mass., 1026
Treatment: See Hearing Aids
DEARHOLT DAYS, Wis., 866
DEATH: See also Coroner System; Murder; Suicide
Accidental: See Accidents, fatal
Cause of: See also under names of specific diseases
cause of, fatalities from boxing, 455
cause of, from intercostal use of efocaine, [Angerer & others] *550
cause of, in physicians, [Poynton] 1379—C
cause of, in silo, 893
cause of, medicolegal experiences under Ohio coroner's system, [Landé & Boone] *179
cause of natal day deaths, [Bundesen] *466
cause of needless neonatal deaths, [Clifford] *473
Examination after: See Autopsies
of Fetus: See Fetus; Stillbirth
of Infants: See Infants, mortality
of Physicians: See list of Deaths at end of letter D
Rate: See Vital Statistics
sudden, in childhood and pulmonary thrombosis, [Emery] 885—ab
sudden, in infancy, [Nevius] 593—ab; 1428—ab
War Dead: See Korean War, Heroes
DECORTICATION, Chemical: See Streptodornase-Streptokinase
DECUBITUS
complications and their metabolic relationship, [O'Connell & Gardner] *709
treatment, dried blood plasma-Peruvian balsam paste, [Clark & Rusk] *787
DEFENSE: See Civilian Defense; Medical Preparedness
U. S. Department of: See Armed Forces
DEFERMENT, Military: See Medical Preparedness
DEFICIENCY DISEASE: See also Beriberi; Pellagra; Rickets; Vitamins
influence of pregnancy, lactation, growth, and aging, [Spies] *185
DEFINITION: See Terminology
DEFORMITIES: See Abnormalities; Crippled; Poliomyelitis
DEGENERATION
Hepatolenticular: See Lenticular Nucleus degeneration
DEGENERATIVE Joint Disease (osteoarthritis): See Joints
DEGLUTITION: See Swallowing
DEGREES
baccalaureate, graduates with in medical schools in, *120
DEITRICK, J. E., Medical Schools in U. S. at the Midcentury, *106; 149—E; 1325
DELANEY, J. P., U. S. House Committee on toxicity of chemicals in food, [Seevers] *1331
DE LEE Lecture: See Lectures
DELIRIUM
acute, treated by hibernation, France, 1197
DELIVERY: See Labor
DEMENTIA PRECOX
treatment, lobotomy, prognosis, Sweden, 1569
treatment, prefrontal procaine injection, [Myers & others] *1015
DEMEROL: See Meperidine
DENMARK: See Danish
DENTAL Caries: See Teeth
DENTIFRICES
chlorophyll and deodorization, 718—E; [Westcott; Ryan; Langley] 749—C; [Hein] 1571—C
DENTISTRY: See also Dentifrices; Jaws; Teeth
dentists and National Health Service, London, 874
DENVER Clinical Meeting: See American Medical Association
DEODORANT: See Odor
DEPARTMENT of Defense: See Armed Forces
DERMATITIS: See also Eczema
actinic, 1232
antihistamines omitted from N.N.R., (Council report) 1447
Atopic: See Neurodermatitis
chromate, (Council article) [Walsh] *1306
Contact: See Dermatitis venenata
exfoliative, from phenylbutazone (butazolidin), [Fishman & Reynolds] *642
gold cause of, cortisone treatment, [Den Oudsten] 888—ab
Industrial: See Industrial Dermatoses
venenata from melmac cast, [Conrad & Ford] *557
DERMATOLOGY: See also Skin; under names of specific skin diseases
American Academy of, meets in Chicago, 1188
American Board of: See American Board
role of dermatologist in treating skin cancer, [Lamb] *1509
DERMATOPHYTOSIS: See Tinea capitis
DERMATOSIS: See Skin disease
Industrial: See Industrial Dermatoses
DERMOGRAPHISM
black, discoloration beneath gold ring, [Brauer] 1416
DESENSITIZATION: See Allergy
DESOXYCORTICOSTERONE
acetate, effect on diabetic ketosis, [Rose] 1485—ab
acetate plus antazoline for vomiting in pregnancy, [Youssef] 600—ab
treatment of Addison's Disease with injections of "long-acting" esters, [Sorkin] 1317—ab
DESOXYRIBONUCLEOPROTEID
enzymatic decortication, [Halse] 687—ab
DEVICES: See Apparatus
DEVIL'S Grip: See Pleurodynia, Epidemic
DEXTRAN (Expandex; Plavolex)
clinical evaluation of Plavolex, as plasma volume expander, [Bowman] *24
lectures on, Norway, 1470
treatment in burns, evaluation, [Johnston] 166—ab
DEXTROSE: See Glucose
DIABETES MELLITUS
acidosis, desoxycorticosterone acetate effect on ketosis [Rose] 1485—ab
acidosis, epinephrine ketosis, [Müller] 1594—ab
acidosis, prognosis in, [Zieve] 585—ab
American Diabetes Assn. award for paper, 631
at A. M. A. St. Louis Clinical Meeting, 494
brittle, 892
care of infant of diabetic mother, (replies) [Levitt; Fischer] 528
case finding, blood sugar screening tests, [McLoughlin & others] *182
case finding, program, Ohio, 963
case finding, report on 2,000 cases of glycosuria, Paris, 664
clinic, field work of, London, 1038
complications: insulin and glucose control pain from potassium poisoning in Kimmelstiel-Wilson syndrome, [James & others] *545
complications: myelopathy, [Garland] 685—ab
complications: neuropathy, [Hirson] 685—ab
complications: pregnancy, management of, [Tolstoi & others] *998
complications: retinitis proliferans, 1597
Diagnosis: See Diabetes Mellitus, case finding
drugs to avoid in, 257
fair, New England, 1027
forum, Wis., 156
headache in diabetic after eating fats, 894
hypophysectomy in man, [Luft] 171—ab
impotence in, its mechanism, prognosis, treatment, 1066
in aged, 1433—ab
infants born to diabetic mothers, [Tolstoi & others] *1000
life expectancy in diabetics, 1187
renal glycosuria progress into? [Robers] 1585—ab
spontaneous, in dogs, [Ricketts] 1209—ab
symposium on by New York Diabetes Association, 436
treatment, hypophysial roentgen, [Pais] 1586—ab
treatment, regional planning of diabetic services, London, 661
DIABETES, RENAL: See Glycosuria, renal
DIAGNEX: See Quinine Carbacrylic Resin

V 15
1951

DIAGNOSIS: See also under names of specific diseases
Case Finding: See Diabetes Mellitus; Tuberculosis
Fred Bauer Waits (film review), 1308
in general practice, British Medical Association review, 1195
push-button diagnosticians, 1421—ab
screening (multiple) summary, (Council report) *1042
screening procedure for abnormal carbohydrate metabolism, [McLoughlin & others] *182
DIALYSIS: See Kidneys, artificial
DIAPHRAGM
examination in trichinosis, [Bourns] 598—ab
Hernia: See Hernia, diaphragmatic
DIAPHRAGMATIC SPASM, Epidemic: See Pleurodynia, Epidemic
DIARRHEA: See also Dysentery
infantile, acute abdominal conditions in, Mexico, 234
DIATHERMY
electrocoagulation of hypophysis in Cushing's syndrome, [Arner] 1123—ab
equipment, conference on regulation of, 1187
microwave, what advantages over short wave diathermy? 1231
DIBENZYLINE
treatment plus sodium restriction in hypertension, [McGill] 1205—ab
DICHLORODIPHENYLTRICHLOROETHANE: See Chlorophenothane (DDT)
DICKINSON Lecture: See Lectures
DICOUMARIN; DICUMAROL: See Bishydroxycoumarin
DIENCEPHALON: See Brain
DIET: See also Food; Nutrition
Chilean Society of Dietetics, anniversary, 1036
Infant's: See Infants, feeding
Jewish dietary laws: sodium in processed meat, [Kirsch] 1472—C
Protein in: See Protein
Reducing: See Obesity, treatment
Salt-Free: See under Salt
Vitamins in: See Vitamins
DIETHYLCARBAMAZINE (Hetrazan)
treatment of creeping eruption, [Kelley] 1210—ab
DIETHYLSTILBESTROL
toxicity: breast cancer, [Emerson] 680—ab
U.S.P., N.N.R., (Bowman) 1447
DIGESTION: See Indigestion
DIGESTIVE SYSTEM: See also Indigestion
diagnosis of allergy, Belgium, 1111
DIGITALIS
intravenous digitalization, 1496
to suppress extrasystoles, (reply) [Abraham] 894
DIHYDROERGOTAMINE
treatment of intoxication from irradiation, [Werner] 71—ab
DIHYDROSTREPTOMYCIN
streptomycin and, compared, [Mahady] 754—ab
toxicity: fatal staphylococcus enteritis, [Fairlie & Kendall] *90
treatment of pulmonary tuberculosis, [Halde] 754—ab
treatment plus p-aminosalicylic acid effect in artificial pneumothorax, [Birath] 1210—ab
treatment plus penicillin in bacterial endocarditis, [Geraci] 1577—ab
treatment, short term combined, in endocarditis, [Geraci] 1577—ab
DILATORS: See Arteries, coronary
DIMENHYDRINATE (Dramamine)
cure for seasick seamen, Denmark, 445
treatment of Ménière's disease, 1142; (correction) 1460
DIMERCAPROL (BAL)
treatment of bichloride of mercury poisoning, [Dôolan] 1053—ab
treatment of complications of gold therapy, [Watson] 686—ab
p-DIMETHYLAMINOAZOBENZENE
tumors in dogs fed with, [Nelson] 170—ab
DIODONE: See Iodopyracet
DIODRAST: See Iodopyracet
DIOSPYROBEZOAR
[O'Leary] 587—ab
DIOXYLINE (Paveril)
coronary vasodilators evaluated [Russek & others] *207
DIPHENHYDRAMINE (Benadryl)
hydrochloride, cure for seasick seamen, Denmark, 445
DIPHTHERIA
immunization, poliomyelitis after, London, 506
treatment, oxytetracycline, [Lall] 582—ab
DIPLOMA Mills: See Licensure
DIPLOPIA
after ankylosis of temporomandibular joint, 1231
DIRECTORY
of Physicians: See British Medical Register
DIRT: See Dust; Soil
Eating Dirt (Pica): See Appetite
DISABILITY: See Accidents; Blindness; Crippled; Handicapped
Chronically Ill: See Disease
Industrial: See Industrial Accidents; Industrial Health workers absenteeism; Workmen's Compensation
Rehabilitation after: See Rehabilitation
DISASTERS
civil defense director looks at the medical problem, [More] *1007
research, reports wanted on, 1559
DISCOGRAPHY: See Spine
DISCOLORATION
black, beneath gold ring, 455; (reply) [Brauer] 1416
DISEASE: See also Death; Health; Pathology; under names of specific diseases
Absenteeism from work due to illness: See Industrial Health, workers absenteeism
Atopic: See Allergy
Carrier: See Dysentery; Streptococcus
chronic, Commission on Chronic Illness, statement by Dr. McCormick before U. S. House Committee, 730
chronic, group therapy with chronically ill children, [Koven] 1479—ab
chronic, Highland View Cuyahoga County Hospital (photo), 1457
chronic, leiodystonic syndrome in, [Pock-Steen] 1593—ab
chronic, National Conference on Care of Long-Term Patient, (President's page), 857
chronic, relative frequency of, especially in older persons, 1177—E
chronic, standardization of nursing homes, [Murdock] *1442
Deficiency: See Deficiency Disease
Diagnosis of: See Diagnosis
Hazard: See Industrial Diseases
Industrial: See Industrial Diseases
is chemical and chemically correctable, [Spies] *185
Mental: See Mental Disorders
Nomenclature: See Terminology
of Old Age: See Old Age
Patients: See Patients
Physical-Mental Relationship: See Psychosomatic Medicine
Prevention: See Preventive Medicine
Rate: See Vital Statistics
reportable, certain forms of cancer in 1953, Sweden, 49
Sickness Insurance: See Insurance, sickness
sickness survey by Washington State Medical Association, 497
superstitions regarding, in India, [Bowers] *1168
Treatment of: See Hospitals; Therapeutics
Volunteers: See Research, volunteers to aid
DISINFECTION: See Antisepsis; Sterilization, Bacterial
DISLOCATION: See Hip
DISTOMATOSIS: See Distomiasis
DISTOMIASIS
pulmonary paragonimiasis, [Roque] 449—ab
DISULFIRAM (Antabuse; Tetraethylthiuramdisulfide)
alcohol reaction, management of alcoholism, [Feldman & Zucker] *898
treatment, 5 years' experience, [Martensen-Larsen] 1484—ab
DIURETICS
mercurial, detecting salt depletion during cardiac therapy with, [Silverman] 64—ab
mercurial, hypoalbuminemia in complications from, [Diengott] 252—ab
DIVERTICULA: See Duodenum; Stomach
DIZZINESS: See Vertigo
DOCTORS: See Physicians
DOCTORS DRAFT LAW: See Medical Preparedness
DOGS: See also Rabies
pet, toxoplasmosis from, [Prior] 1204—ab
spontaneous diabetes mellitus in, [Ricketts] 1209—ab
DOHENY Foundation: See Foundations
DONATIONS: See Fellowships; Foundations; Prizes; Research grants; Scholarships
DONORS: See Blood Transfusion
DORSACAINE: See Benoxinate Hydrochloride
DORSET Brand Diet Pack soups, 801
DRAFT: See Medical Preparedness
DRAFTING ROOM
odor of carbon tetrachloride in, 1231
DRAKE, DANIEL (1785-1852)
tribute to, 555—ab
DRAMAMINE: See Dimenhydrinate
DRESSINGS: See also Cast
plastic, for burns and operative wounds, Sweden, 1569
DRINKING: See Alcoholism
DRIVERS; Driving: See Automobiles
DROMORAN: See Racemorphan Hydrobromide
DROPSY: See Ascites; Edema
DRUGGISTS: See Pharmacists
DRUGS: See also Pharmacology; and under names of specific drugs; Medicolegal Abstracts at end of letter M
Addiction: See Barbiturates; Narcotics
allergy, endangitis obliterans as, [Schmid] 982—ab
Anesthetic: See Anesthesia
changes in 1953 British Pharmacopeia, 1378
N.N.R.: See under names of specific products
new generic and brand names recognized by Council, 801; 1447
Prescriptions: See Prescriptions
resistant organisms during treatment with isonicotinic hydrazides, [Coates] 593—ab
Self-Medication: See Self-Medication
Therapeutic Use: See also Chemotherapy; under names of specific diseases
therapeutic use, course in advances in, Wash., 1027
therapeutic use, on aged patients in state mental hospital, [Levy] *1260
to avoid in diabetics, 257
U. S. Food and Drug Administration: See Food
U.S.P.: See under names of specific drugs
DRUMMOND Fellowship: See Fellowships
DRUNKENNESS: See Alcoholism; Medicolegal Abstracts at end of letter M
DRY CLEANING
toxic peripheral neuritis from chemical reagents, 1232
DUBRA'S Vaccine: See Tuberculosis immunization
DUCTLESS GLANDS: See Endocrine Glands
DUCTUS ARTERIOSUS
patent, loud fetal heart murmur, 991
patent, with pulmonary hypertension, [Hultgren] 681—ab; [Chávez] 764—ab
DUCTUS DEFERENS: See Vas Deferens
DUES: See American Medical Association membership
DUKE UNIVERSITY
annual symposium, N. C., 1185
DUMPING SYNDROME
after gastrectomy, 1068
DUNGER'S METHOD
for staining eosinophils, 1067
DUNHAM Lecture: See Lectures
DUODENUM
cancer (pancreaticoduodenal), [McDermott] 173—ab
diverticula, [Horsley] 250—ab
hemorrhage, difficulty in recognizing, 1287—E
lung circulation time in portal hypertension, Brazil, 1376
pain patterns, 556—ab
Ulcer: See Peptic Ulcer
DUPUYTREN'S Contracture: See Contracture
DUST
chest pain in farmers from exposure to dust from soil, [Williamson] 164—C
disability from inhaling grain dust, [Cohen] 61—ab
Inhalation of: See Pneumonoconiosis
poisonous, containing mercury compounds, protecting farmer from, 1161—ab
DU VIGNEAUD, V., synthesis of pituitary hormones, 1524—E
DWARFISM
Renal: See Osteodystrophy, renal
DYES: See also Stains and Staining
storing ampuls for spinal anesthesia: use of color indicator, [Lewis] 30—C
DYING: See Death
DYSENTERY: See also Diarrhea
bacillary (acute and chronic) and chronic ulcerative colitis, [Felsen & Wolarsky] *1069; [Palmer] 1199—C
bacillary, incidence; detecting carriers; prevention with antibiotics, [Cheever] 1199—C
DYSGERMINOMA (seminoma)
survival rates, [Kimbrough & Cook] *1436
DYSPEPSIA: See Indigestion
DYSPHAGIA: See Swallowing, difficult
DYSPLASIA
fibrous (Jaffe-Lichtenstein), [Braunwarth] 524—ab
DYSPNEA: See Asthma
DYSTONIA
leiodystonic syndrome in indigenous disease, [Pock-Steen] 1593—ab
DYSTROPHY: See also Osteodystrophy
Muscular: See also Myasthenia Gravis
muscular, fourth clinic, D. C., 1102
muscular, research grants by Muscular Dystrophy Associations of America, 572, 962

DEATHS

A

Abbott, Henry Bacon, 576
Abrams, Corydon Jackson, 870
Abramson, Arthur Joseph, 1562
Aguglia, Vincent B., 1295
Ahrens, Harvey, 1108
Aird, John William, 1463
Albrecht, Mordecai, 442
Alexander, George, 1295
Alexander, Harry H., 576
Allen, Abbott William, 502
Allen, Edward Carson, 228
Allen, Joseph R., 1463
Allen, Joseph Randolph, 228
Allen, Myron Bartlett, 576
Altshuler, Abraham Magnus, 576
Anderson, Axel Hjalmar, 1295
Anderson, Charles Rhodes, 1562
Andronis, Nicholas, 967
Anking, Albert Carl, 1191
Arnett, James Horatio, 44
Arnold, Burt G., 44
Arnold, Laurie James, 228
Atkinson, Howell, 1374
Atwood, Abner Lowe, 1463
Aubin, Alexander, 44
Aurin, Emil Carl, 1031
Austin, Fred H., 870
Axe, Ross Harrison, 576

B

Bagwell, Barnum Williams, 44
Bailey, Alfred S., 576
Bailey, Desmond Mark, 1463
Bailey, Louis John Carrick, 502
Baily, Howard Houghton, 442
Baker, Walter Eugene, 742
Baldwin, William Sherman, 1031
Ball, Otho Fisher, 160
Balsinger, William Ernest, 870
Bancroft, George Raymond Jr., 1031
Barham, Frank Forrest, 576
Barker, Pauline Quillin, 576
Barkley, A. Wray, 870
Barnaby, Charles W., 228
Barnes, Frank Haslehurst, 742
Barnes, Tiffany, 1562
Barnett, Thomas Meriwether, 1374
Barr, Frank Ellis, 1191
Barron, Oliver Bridges, 502
Bartechi, Ferdinand Aloysius, 1374
Bartol, Edward Francis Washburn, 576
Bateman, Wilbert Charles, 742
Bates, Joseph Knox, 576
Baxter, James Hubert, 1463
Baxter, Lewis Thomas, 1463
Bean, John Lacy, 967
Beattie, Joseph Hoyt, 1191
Bechtol, Emery Alvin, 1463
Beckes, Norman E., 44
Beebe, Jay Lee, 1463
Beehler, Louis L., 1463
Behrens, Alvin, 442
Bell, Carl Wendell, 44
Bell, Robert Fleming, 1463
Bellehumeur, David Stanislaus, 1031
Benjamin, Arthur Edwin, 1462
Bennet, Pearl R., 1031
Benton, George R., 1463
Benz, Alvin Hermann, 1463
Bernheim, Ruth Grace, 742
Best, Alonzo Lee, 160
Beyer, William, 502
Billion, Thomas P., 502
Birnie, John Mathews, 576
Bitten, Robert Mooney, 1031
Black, Allan Brown, 967
Black, Emil Claudius, 228
Black, Glenn Raymond, 1031
Blackwood, James Magee, 443
Blair, Harold Albert, 1295
Blaisdell, Iri Hazard, 742
Blancard, William, 576
Blanton, Marvin Asbury, 502
Blechman, Elihu David, 1031
Blevins, William Joseph, 576
Blood, Hiram Isaac, 1191
Bobbitt, James Douglas, 576
Bobo, Arlington Henry, 967
Bodkin, Dominic George, 576
Boland, Frank Kells, 1562
Boland, Matthew Joseph, 44
Bollmeier, Ludolf Nicholas, 160
Bonathan, Alvin Thomas, 502
Bond, Van H., 1031
Boothby, Walter Meredith, 44
Borgen, Alfred Edwin, 743
Bosworth, Ralph Lyman, 1191
Bower, Ernest C., 870
Bowman, Earle Ledbetter, 655
Bowmer, Otho Cassius, 1295
Boynton, Lloyd V., 228
Boys, Charles Edwards, 44
Bozorth, Squire Smith, 577
Braden, Albert Henry, 228
Bradford, Edward B., 577
Brainard, Benjamin F., 743
Breitenbecher, Edward Robert, 44
Bremer, Benjamin Franklin, 1295
Brennan, Edward Lizarian, 1462
Brenner, Ivan Ernest, 577
Brentan, Emanuel, 502
Briden, Vayle Spencer, 577
Briggs, Harry Arthur, 44
Briscoe, Hugh Alan, 228
Broadwin, Isra Tobias, 443
Brock, Henry Herbert, 1295
Brody, Myer, 1191
Brooks, Cadmus Marvin, 743
Brooks, Edward Benjamin, 1295
Brooks, LeRoy, 502
Brown, Alexander Gustavus Jr., 1191
Brown, Archie Lee, 1191
Brown, Barton Levi, 1463
Brown, Clarence Raymond, 503
Brown, Columbus, 870
Brown, Frederick Willard, 160
Brown, Homer Scott, 967
Brown, Thomas Jacob, 502
Brownell, Emily Margaret Baer, 228
Brummette, James Sutton, 967
Bryans, Charles Iverson, 1031
Bryant, Daniel John, 870
Bryant, Oliver Roy, 577
Bryson, Howard Russell, 45
Buckley, Charles Frederick, 442
Buckner, Frank Ingram, 1562
Bugher, Corwin E., 502
Bullen, Benjamin Wells Jr., 870
Burbridge, Leonidas T., 1031
Burgess, Marshall E., 1295
Burgner, Benjamin H., 1295
Burke, Donald Vincent, 577
Burke, Thomas Jerome, 577
Burnett, Harry Webster, 1562
Busching, Howard Ellsworth, 229
Buschmann, Bronson, 229
Busicco, Philip Salvatore, 577

C

Caccini, Attilio Mario, 1463
Caldwell, James Clarence, 577
Caldwell, John Ewart, 870
Caldwell, Robert Dennis, 870
Cameron, Donald Archibald, 1031
Campau, George Henry, 1463
Campbell, Colin Clyde, 229
Campbell, Edward J., 577
Campbell, Hiram Gill, 1296
Campbell, James McLain, 743
Canavan, Myrtelle Moore, 1295
Carrico, Carl C., 743
Carroll, Gerald John, 1463
Carter, Curtis Braxton, 1463
Cartmell, Harry D., 870
Carver, William Franklin, 1463
Cary, Eugene, 1463
Case, Edward Franklin, 229
Catlett, Marshall Burr, 1295
Causey, Frederick Archibald, 1463
Cayley, Frank Joseph, 1463
Caywood, James Robert, 1463
Challed, Don Seridan, 1031
Chaloupka, Arthur James, 655
Chamberlin, Donald Tillinghast, 1295
Chapman, Walter Irving Jr., 1191
Cheifetz, Irving, 655
Chesner, William Anthony, 655
Christophe, Herman C., 1296
Clagett, Arthur Neville, 870
Clark, Donald Victor, 577
Clark, Richard Harry, 1296
Clarkson, James A. Coleman, 870
Clymer, George, 967
Coate, Charles Rufus, 45
Cobb, Benjamin Elden, 1031
Cochran, Harry Walton, 577
Cochran, Marcellus Francis, 870
Cocks, Charles Edward Jr., 1297
Coe, Marie Condee, 1296
Cogswell, George Proctor, 443
Colehour, Samuel Phillip, 1463
Coler, Eugene Seeley, 1563
Collins, Leonard James Jr., 658
Comerer, Jacob Alvin, 1031
Conklin, Rush West, 1296
Cook, Edgar Baldwin, 743
Cook, Frances Helen, 967
Cooper, Howard Newton, 577
Cornet, Louis Anthony, 1296
Courie, Edmonson Shorter, 655
Cowan, John Rice, 743
Cox, Henry McCall, 870
Cox, Wesley Cintra, 658
Coy, Warren Deweese, 443
Crabb, George Melville, 1191
Craddock, Paul Tulane, 1464
Crandall, Frank Guilford Jr., 576
Crawford, James Howard, 1031
Criscillo, Serafino Lewis, 1031
Cromeans, Randall Elias, 577
Crosby, Edward Harding, 1191
Crowe, John William, 160
Crowe, Robert Latta, 743
Cuneo, Peter Joseph, 743
Curll, Clyde Leslie, 45
Currer, Paul Richard, 1464
Curtis, Alfred Lee, 967
Curtiss, Fred Decker, 229

D

Dahl, Gerhard A., 655
Dale, Peter Hoffer, 1192
Dame, Louis Paul, 229
Danglade, James Harold, 229
Danzis, Maximillian, 1295
Davenport, Charles Albert, 1192
Davies, Frederic Bard, 577
Davies, Matthew Wyn, 1296
d'Avignon, Francis Wright, 1464
Davis, Joseph Edward, 743
Davison, Thomas Callahan, 1295
Dayton, George Farbridge, 967
Deicher, Henry F., 443
De Lamater, Hasbrouck, 1030
Delph, John Francis, 1462
Derbyshire, Albert L., 1031
Deutsch, Isadore Herman, 743
Dewey, Leonard Adolph, 967
Dickinson, Charles Baldwin, 1296
Dillehunt, Richard Benjamin, 1374
Dinan, Joseph Francis, 1464
Dintenfass, Henry, 655
Dixon, Chester Darwin, 45
Dixon, Winfield Scott, 443
Doak, Nathaniel Parillus, 577
Dobbins, Thomas Carson, 870
Dodson, Ross, 655
Dohrmann, George, 870
Doles, James Wesley, 1296
Donahue, James Joseph, 577
Donathan, Earl Raymond, 1464
Donovan, William Henry, 1374
Doran, Martha Venetia, 1463
Dorminy, James Norwood, 502
Dotson, Charles Harvey, 1192
Dougherty, William Sylvester, 45
Downing, Perley Edwin, 160
Dowson, Albert Wilson, 1464
Drake, Clifford Cochrane, 229
Drake, William Francis, 502
Duden, William Robert, 1192
Dudgeon, Howard Rush, 442
Duffy, Edward Anthony, 577
Dumm, Colin Marcus, 1464
Duncan, Marion W., 1031
Duncan, Melvin Dewey, 1108
Duncan, Will Cunningham, 1464
Dunn, A. Henry, 577
Dunning, Edgar Clarence, 1108
Dunton, Harold Roy, 45
Dwyer, Patrick James, 443
Dye, James A., 870
Dyer, John H., 743
Dyko, William Edward, 870

E

Early, William Leyton, 1108
Eaton, Robert Lee, 655
Eaton, William Oliver, 655
Eberhardt, Jacob Pope, 45
Eckhardt, Joseph Carl Augustus, 743
Edler, Robert Karl, 443
Eigler, Charles O., 1296
Eikenberry, Kenneth W., 45
Einhorn, Max, 1031
Ellis, Edwin Milton, 45
Elmer, Matthew K., 443
Engelbrelt, Joseph James, 579
Engle, John Max, 870
Engman, Martin Feeney, 1108
Epler, Blanch Nettleton, 577
Erb, Howard Renninger, 1464
Erdmann, Adolph Frederick, 577
Estrem, Carl O., 45
Evans, Joseph Patton, 577
Ewing, George Winburn, 1108
Eyman, William George, 743

F

Falk, Victor Sofus, 655
Farrell, Edgar Atlas Holt, 655
Farrish, George Clayton, 45
Farthing, Robert R., 1464
Fecteau, Adelard, 1374
Fedde, Gabriel Martin Nathanael, 1108
Fergusson, Frederick William, 1374
Ferlaino, Frank R., 742
Fisk, Frank Byron, 502
Fitzpatrick, Charles Mooney, 655
Fleming, Albert, 655
Fleming, Charles LeRoy, 1031
Flothow, Paul George, 1108
Flynn, David Storrs, 1296
Flynn, Joseph P., 655
Foley, Francis Edward, 1374
Foley, Harry Thomas, 1108
Folsom, Charles W., 1108
Fordyce, Claude Powell, 577
Fortney, Frank Dennis, 443
Foster, Herbert West, 160
Foster, Robert Hale, 45
Fouche, James Sample, 1374
Fox, Charles Moses, 870
Fraden, William, 1031
Francis, John Wesley, 1296
Franklin, Paul Hutchins, 870
Franklin, William Essex, 443
Frazier, Harold Langford, 1108
Freas, Martin Wesley, 1374
Freedman, I. Val, 502
Freeland, Frank, 1374
French, William Gayle, 870
Friedman, Paul Norman, 577
Frisbey, William Redmon, 577
Fritz, Clarence Henry, 502
Froyd, Melvin Frankford, 870
Fruth, Harold Edgar, 1374
Fry, John Lewis, 1108
Fuchs, Julius, 502
Fuller, Tilman, 229
Fulton, Gavin, 1108
Furusawa, Takashi, 1464

G

Gaertner, Erasto, 225
Gahagan, Wiley W., 1192
Gaikins, George Alain, 577
Gallagher, Patrick Joseph, 443
Galvin, Thomas Keough, 1108
Gammill, James L., 1296
Gano, Charles Harkness, 743
Garland, Frederick Eugene, 576
Gates, Ira Norman, 1031
Gay, Nathaniel Scales, 577
Gee, Lemuel Edmond, 229
Gehring, Edwin Wagner, 577
Gibb, Alice Stearns, 443
Gibby, Herbert B., 442
Gibson, Ora James, 45
Gibson, William Henry, 870
Gilbert, George Richardson, 743
Gilliland, Caroline Jane, 1108
Gilmore, Howard Manning, 1031
Gilmore, Lewis Daniel, 1108
Ginder, Floyd Edwin, 578
Giordano-Cortese, Modesto, 743
Girouard, Joseph Arthur, 1374
Glait, Morris Arthur, 44
Glazer, Henry G., 1464
Gobar, Franklin Harold, 1374
Goggins, Robert Joseph, 1296
Goldschmidt, Myer, 1192
Goldsmith, Norman Robin, 1191
Golub, Jacob Joshua, 967
Gonzalez, Aurelio Andres, 502
Good, Benjamin F., 1464
Good, Charles Frederick, 1374
Goodrich, William Ray, 443
Gordon, Donald, 442
Gordon, Donald Louis, 1374
Gould, Arthur L., 1031
Granata, Tancredi Giovanni, 1464
Granger, William Leonard, 1464
Graveline, Ernest Louis Jr., 1297
Gray, Denver Francis, 870
Green, Edgar Vernon, 1562
Green, James Henry, 502
Green, Thomas Hall, 1562
Greenwalt, Kenneth E., 1192
Gregory, Lorenzo Theophilus, 1032
Greulich, Cornelius D., 656
Griffin, James Olin, 578
Griffin, Meredith T., 656
Griffin, Richard W., 443
Griffith, Martin E., 229
Griffith, William Allen, 160
Grillo, Vincent James, 1375
Grone, Robert Yocum, 578
Grussner, Albert, 656
Gunn, John William, 1192
Guterman, Henry Samuel, 502

H

Hagen, Henry Otto, 870
Hagood, John W., 1109
Haig, Thomas Raymond, 229
Haight, Julius Eugene, 1296
Halford, Francis John, 1191

V 15
1953

Deaths—Continued
Hall, Fred Watt, 1375
Hall, Lynn Thompson, 443
Hall, Willis, 502
Hammers, James S., 656
Hanlon, Clement Richard, 1562
Hansen, Charles Ola, 1375
Hanson, Albert N., 443
Hardman, Charles Terrell, 1562
Harlan, Lee Henry, 1296
Harris, Dean Wilson, 229
Harris, Frederick William, 578
Harris, George Gano, 1375
Hartzell, Homer John, 1562
Harvey, Clifford Dawes, 442
Harvey, Samuel Clark, 442
Hatchett, William Clifton, 1375
Hatfield, Richard Henry, 1109
Hawley, Nelson Joy, 1375
Hayes, Milton Emerson, 45
Haynes, Charles Elmer, 1192
Hedrick, Donald William, 229
Heichler, Joseph, 1192
Heil, Ulysses S. Grant, 160
Hellesen, William Edward, 1109
Hemminger, John Ross, 1192
Hendrickson, Harold Wesley, 1563
Henritzy, Oscar Edwin, 1375
Henry, Frank Charles, 1032
Henry, Myron Ormell, 1108
Herring, Harold Mandeville, 1192
Herron, William Floyd, 871
Hershberger, Lloyd Ralph, 656
Hertel, Paul, 1563
Hess, H. Lewis, 443
Hewitt, John Michael, 1032
Higgins, Martin Andrew, 1109
High, Charles Vernell Jr., 871
Highsmith, Emmett Dewitt, 655
Highsmith, Luther Byrl, 1109
Hill, Walter Coit, 871
Hilliard, Alexander W., 656
Hoag, R. B., 578
Hoffmann, Alfred Anthony, 656
Hogan, Austin, 1563
Hohf, Silas Matthew, 228
Hoitt, George Barnard, 1109
Holloway, Luther William, 45
Hollowell, Claude Velmont, 45
Hood, Charles Sumner, 1375
Hoover, James J. D., 229
Horan, Michael Joseph, 502
Horn, Isaah Buford, 443
Hoshall, Frank Adelbert, 655
Houck, William Selbert, 1375
Houser, Daniel Cary, 871
Houston, Grant, 871
Houston, Hugh, 656
Howard, Joseph Henry, 1462
Howe, Julian Menzo, 503
Howell, John Valentine, 1563
Howland, Charles Francis, 1032
Hultkrans, Joel Carl, 656
Hunt, Reuben Heywood, 656
Hunt, Warren Coe, 656
Hunte, August Frederick, 443
Huson, William Joseph, 229
Hyde, Harriet Baker, 503

I

Ikins, Ray George, 871
Isaacson, Barney, 1109
Ivec, Martin J., 1375
Iwersen, John Christian, 656

J

Jackson, Bruce Emmett, 1375
Jackson, John Wagner, 871
Jackson, William Henry, 1563
Jacobs, Luster Irvin, 503
James, Arthur Gregory Boswell, 743
James, Maurice Clayton, 1109
Jamison, Alfred, 229
Jegi, Henry A., 655
Jennings, Edward S., 1375
Jermstad, Robert James, 1375
Jerrick, Walter Fitzgerald, 1375
Jobes, John Bell, 1375
Johnson, Karl Osborn, 443
Johnson, Lee T., 443
Johnson, Leighton Foster, 228
Johnson, Rezin Pritchard, 871
Johnston, Harold Alvah, 1032
Johnstone, Charles William, 1032
Jones, Everett Orville, 578
Jones, Frank Collett, 1375
Jones, Henry Durst, 229
Jones, Maurice Leland, 1375
Jones, Mortimer Dunham, 1032
Jones, Zebulon Baird Vance, 1563
Jonez, Hinton Denny, 1192
Jordan, Thomas Scott, 1192
Joseph, Walter Max, 443
Joslin, Doyle, 503
Jost, William Edward, 1375
Joyce, Edgar Collins, 229

K

Kalayjian, Dikran Sarkis, 1032
Kapner, Zadok, 1296
Karcher, James Franklin, 656
Katzman, George Manual, 1032
Kauffman, Ira Dwight, 1375
Kaufman, Paul Myron, 656
Kaveney, Joseph James, 578
Keane, James Patrick, 670
Keeler, Harold Raudenbush, 443
Keeling, Irene Cutter, 1032
Kelley, John Thomas Jr., 443
Kellum, Monford Romain, 443
Kemper, Americus Judson, 871
Kenney, Joseph Raymond, 1192
Kenney, Stephen A., 1109
Kerr, Ulysses F., 503
Keskey, George Isaac, 578
Kimmel, Benjamin Bruce, 656
Kimmelman, Simon, 1032
Kindred, John Cramer, 1462
King, Hubert Charles, 1296
Kirk, Marion Singleton, 1109
Kirksey, James Jackson, 229
Kirkwood, Robert Carnahan, 229
Kitson, Verner H., 1563
Klapproth, Herman, 578
Klein, Harry, 871
Klein, John, 743
Kleinman, Maurice, 578
Klopstock, Erich, 1109
Knapp, Charles Whittemore, 1032
Knox, John, 578
Kolb, Thomas Victor, 1109
Koon, Alpheus Cary, 1563
Koons, Charles Edward, 1109
Korh, David Adam, 1464
Kortsch, Ferdinand Paul, 656
Kownacki, Francis Joseph, 1375
Kretlow, Fred A., 1109
Krzysko, Stanley Leon, 656
Kummel, Max, 656
Kupelian, Nessib Simon, 1464
Kushell, Maria Dora, 229

L

Lacock, Lester Earle, 656
Lally, Francis Henry, 656
Landau, Benjamin G., 503
Landauer, Seward L., 1192
Lane, Irvin J., 1464
Lane, John David, 743
Lang, John Henry, 1375
Lanzafame, Sare Anthony, 1464
Laslie, Carney Graham, 1032
Latz, Benno Ernst, 1109
Lauder, Clark Hays, 1109
Laurent, Francis Victor, 229
Lavy, William S., 1296
Lawless, Ambrose Thomas, 1108
Lawson, David J., 656
Lawson, Sidney B., 1109
Layton, Roy Wilfred, 1296
Lazarus, George Fred, 1109
Legat, Mary B., 1296
Leitchuh, Linus Frederick, 229
Levin, Harry Maurice, 1296
Lewinski, Michael Lewin, 503
Lewis, Andrew Llewellyn, 1109
Lewis, John Francis, 1296
Lewis, Margaret C., 160
Lilien, Adolph Abraham, 1192
Lindsay, Harry Clubb Lodge, 1109
Lindsay, James Adams, 743
Lindt, Harriet L., 1464
Link, Joseph John, 743
Lipkis, Abram, 1375
Little, Theodore Alvin, 1375
Liva, Arcangelo, 742
Lobsenz, Herbert, 1374
Loeser, Wilhelm, 443
Lomax, Claude Carl, 578
London, Stephen, 578
Londrigan, Joseph Francis, 1295
Long, Samuel Calvin, 578
Longmire, Victor Melton, 443
Love, George Robert, 578
Lucas, Wilbur Wayne, 443
Lueke, Alexander William, 1375
Lurie, Solomon L., 1375
Lutes, Lester L., 670
Lyda, Gideon Colwell, 1464
Lynch, Richard Alphonsus, 1032

M

McBryde, Malcolm Hugh, 1032
McCall, James Herald, 1464
McCarthy, William Reginald, 656
McCaslin, Hugh Towles, 1032
McCastline, William Henry, 160
McClure, William Charles, 1109
McCord, Ollie Hagan, 1032
McCormick, Roscoe Conklin, 444
McDevitt, Bernard J., 1109
McDonald, Dan Moore, 656
McDowell, James Fredrick, 1109
McFarland, Arthur Sidney, 1563
McGinley, Charles, 578
McGrail, William Chance, 503
McGregor, Lorenzo Watson, 656
McIntosh, Arthur Merrill, 871
McKee, Charles Bradford, 503
McKee, Robert Morrow, 578
MacKenzie, Ian, 1464
MacKenzie, Oliver Reynolds, 1032
Macklin, Walter Fullarton, 444
McLain, William Hay, 1375
McLarand, Kenneth Carl, 229
McLean, Isaac William, 1191
McLeod, James Lawrence, 229
McMahan, Edgar T., 503
McManus, James William, 1109
McNerney, Neville Hoodlet, 576
McPherson, Samuel Dace, 1108
McQuade, Edwin Leonard, 655
McQueen, Arthur Frederick, 656
McQueen, Arthur Samuel, 503
MacVeany, Arthur Patchen, 1109
Madara, Joseph Edward, 444
Magargee, George W., 1109
Mahoney, George W., 576
Malick, Ada Luella, 229
Malloch, Thomas Archibald, 1032
Malone, Franklin Jefferson, 1192
Mantooth, John Thomas, 1563
Marcus, Daniel B., 1109
Markel, James Clyde, 1109
Marsh, Arthur Drought, 503
Marshall, Benjamin Maxwell, 656
Marshall, William Norman, 871
Martin, Robert Clarence, 1563
Martin, Walter Evans, 1563
Martin, William Riley, 1032
Masliko, Vandy Frank, 578
Mathisen, George B., 1563
Matternes, James G., 1464
Matthews, Duncan Newton, 1296
Maxwell, George Madison, 1032
Mead, Franklin Braidwood, 1464
Meigs, Benjamin Lyle, 1032
Menk, Paul Ernest, 1562
Mercer, William F., 1109
Meredith, Charles James, 1032
Meridith, Clyde O. Jr., 444
Merrit, William Herbert, 45
Metz, Waldemar Rice, 160
Miles, William Clinton, 1032
Miley, Levi Emerson, 578
Miller, Edward Bernard, 1375
Miller, Elmer Manton, 1032
Miller, Fred E., 1563
Miller, James Edred, 871
Miller, John Hume, 1109
Milligan, Leo Patrick, 160
Milliken, Howard Augustus, 1032
Mills, James Fleming, 503
Minahan, Patrick Robert, 444
Minahan, Thomas, 1032
Mitchell, Edward Dana, Sr., 1563
Mitchell, James Henry, 656
Moloney, Bernard Aloysius, 1192
Montgomery, Robert Russell, 45
Moore, George Henry, 1296
Moore, John Jay, 502
Moore, Joseph G., 1109
Moore, Thomas Kenney, 657
Moosey, Marye Maxine, 1032
Morgenthaler, Sophia, 229
Morley, Grace Clark, 578
Morris, Joseph Bowman, 229
Morris, Zenella Elizabeth Nelson, 657
Moser, Oran Alexander, 1563
Moss, Maurice H., 45
Moxey, Albert Franklsh, 1032
Moyer, Jacob C., 1464
Mozley, Charles Almus, 743
Munn, Wayne Alonzo, 657
Murchie, John Talmadge, 229
Murphy, Eugene Clement, 160
Murphy, Frank Augustine, 1109
Murphy, John Francis, 1031
Murrell, Charles Milton, 1110
Myers, Alonzo Harrison, 1462
Myers, George Thomas, 578
Myller, Ernest, 1296

N

Nalley, Thomas J., 578
Nash, William Harmon, 1110
Nathanson, Millicent E. Flack, 444
Neel, William Hal, 657
Neff, Charles Otis, 657
Nelson, Kenneth Oliver, 1192
Nesbit, Wellwood Mack, 1563
Neves, Carl Albert, 229
Neville, J. C., 229
Neville, William, 444
Newberger, Charles, 1031
Newcomb, James Henry, 657
Newsom, Goebel William, 230
Nicholls, James William, 657
Nichols, David C., 1110
Nichols, Harry, 444
Nolen, Beverly Toon, 657
Norman, J. Standing, 1110
Norris, Joseph Esten, 503
North, Emerson A., 576
Norton, Alva C., 743
Novak, Anna C., 578
Nowlin, Ralph Robert, 871
Null, Frederick Folket, 1464

O

O'Connell, John Patrick, 1192
O'Dell, Lester Ely, 1110
O'Dwyer, Joseph, 1296
Ogden, Leon Gray, 657
Ognibene, Frank Anthony, 657
O'Hara, James Francis Jr., 1192
Oliver, Elbert Wilbur, 1464
O'Neill, Silverton Hollingsworth, 230
Oppenheimer, Arnold, 1464
Orr, William Law, 1110
Ortman, John Wessel, 1110
Overton, Frank, 1191
Owen, William Hamilton, 670

P

Painton, Henry McDonald, 1192
Palay, Lewis, 160
Palmer, C. Harold, 45
Papay, Thomas A., 1110
Parham, Ben Otis, 657
Parker, Merrill Olmsted, 1110
Parkin, Edwin Harris, 503
Pascall, Thomas Myrick, 160
Pasco, George William, 1563
Patton, Benjamin Franklin, 1192
Patton, James Elmer, 1192
Paulsen, Niels Peter, 1192
Pavlo, Samuel George, 1110
Payne, Edward Albert, 1563
Payne, John Edward, 444
Pearce, Charles Tabb, 1110
Pearlman, S. Joseph, 1192
Peeler, Dawkins Monroe, 160
Pember, Clyde Harry, 230
Pence, Charles W., 1296
Penrose, Thomas William, 1110
Perrin, Stuart Henry, 657
Perry, Henry Ernest, 230
Peters, Charles Edward, 1110
Peters, Erwin Emanuel, 578
Peterson, Charles Frederick, 657
Pettit, Roswell Talmadge, 44
Petzke, Ernest A., 657
Phaneuf, Louis Eusebe, 742
Pharris, Crit, 1464
Phillips, Alexander Harold, 1110
Phillips, Bruce Gretton, 657
Phillips, Claude Belford, 1110
Pielemeier, Edward Frederick, 45
Pinkerton, William Alfred, 657
Pion, Phillas Arthur, 45
Pitts, Howard, 578
Placa, James Anthony, 1296
Plumlee, Claude Hamilton, 160
Pond, Erasmus Arlington, 444
Poole, Albinus, 444
Powell, John Wesley, 1563
Power, Eugene Logan, 503
Powers, Emery Byron, 1110
Presnell, George Rollin, 503
Pressman, Abraham, 45
Price, Charles Richard, 1563
Price, Stanley Francis, 1296
Pritchard, William Clarence, 444
Privka, Arkadijs Aleksandrs, 657
Pugliese, Francis Michael, 228
Purdy, Frederick Parsons, 444
Purvey, John Compton, 160
Putnam, John Lancaster, 230
Putney, Robert Hubbard, 657

Q

Quinn, Elwood T., 503
Quinn, Patrick John, 657
Quinn, William Blanck, 230

R

Radford, Arthur Franklin, 657
Ragan, Romulus C., 743
Ramey, Cash Clay Jr., 1296
Ramsdell, Robert LeRoy, 230
Ramsey, Oscar Lee, 1192
Randall, Arthur G., 1464
Randall, Auvigne Mason, 230
Range, William Edgar, 578
Ranson, J. Lester Sr., 657
Ray, George Lewis, 1110
Redditt, George Irby, 1192
Reed, Horace, 1295
Reese, LeRoy Joseph, 1110
Reeve, Edward A. Tanner, 230
Reeve, James Spofford, 1296
Reinicke, Edward Louis, 871
Reinsberg, Karl, 743
Remington, Alvah Childs, 657
Reynolds, Jacob Thomas, 1563
Rhamy, Richard Alan, 658
Rice, Thompson R., 230
Richardson, Anna Root Mann, 743
Richardson, John Purver, 230
Risoli, Joseph Edward, 503
Rizzo, Frank, 1464
Roberts, Aaron Lamar, 578
Roberts, David William, 160
Roberts, John Nunnally, 579
Roberts, Samuel Tize, 444
Robertson, Berdge Ruth, 657
Robertson, Edd Lafayette, 1110
Robertson, Jackson Comer, 1297
Robertson, Moorman Owen, 579
Robinson, Jay Aaron, 1375
Robinson, John Ranson, 45
Robinson, Schuyler C., 1192
Robinson, Shelby Louise Boynton, 657
Rochford, Richard Augustine, 1110
Rodenbeck, Frank, 1110
Roessly, George Rufus, 1563

Deaths—Continued
Rogers, Walter Ferrier Jr., 871
Rooney, Eugene Francis, 230
Rose, Bert Andrew, 1297
Rosen, Harold Leon, 1464
Rosenfeld, Sydney Cyril, 230
Ross, Clarence Wesley, 1110
Ross, Emmy Marie Sophie, 657
Rossiter, Thomas Jerome, 579
Rucker, Marvin Pierce, 1462
Rudd, James Colegate, 1110
Rush, William Madison, 1563
Russell, James Andrew Merle, 1375

S

Sabin, Florence Rena, 1030
Salter, Paul Pullen, 1465
Salyer, Kelson N., 1110
Sancetta, Biagis, 657
Sand, Rene, 1028
Sanford, Conley Hall, 1562
Sargent, William Henry, 1193
Sartor, Thomas Ryan, 871
Savitsky, Nathan, 657
Sawyer, Charles Francis, 503
Schirack, John A., 503
Schlenker, George Henry, 503
Schmidt, Florian Edward, 743
Schmitz, Henry Charles, 1193
Schon, Edward, 1193
Schultze, Joseph Henry, 1563
Schumaker, Cyril William, 1563
Schuricht, Gustav M., 1297
Schwatka, Charles Taylor, 444
Scibetta, Samuel Louis, 743
Scott, James Jacob, 1297
Scott, Paul Newton, 1193
Scott, Thomas Ewing, 45
Seale, Ira Bolton, 444
Sears, Frederick Manning, 579
Seiffert, Isadore, 871
Seitz, Sherwood Bretz, 579
Senescall, Cleve Ridlon, 1563
Sevier, Ernest, 1110
Seyfried, Ernest A. N., 743
Shafer, John Walter, 230
Shaham, Simon, 579
Shapiro, Lawrence Milton, 579
Shaw, Harry William, 1110
Shelton, Harold Jordan, 657
Sheppard, Dempsey Orville, 1193
Shipley, John Thomas, 1563
Shumaker, Howard Keller, 444
Sidell, Samuel, 1110
Siebert, Jacob, 1563
Siegler, Samuel Lewis, 1030
Sill, Joseph, 1465
Silverman, Max Kaufman, 871
Simmons, Channing Chamberlain, 502
Sloan, Charles Elmer, 1110
Smith, Bernard Fletcher, 444
Smith, Clarence Austin, 1031
Smith, Francis Michael, 230
Smith, Henry Greene, 579
Smith, James Monroe, 657
Smith, Loran Eugene, 1110
Smith, Morton Hartman, 230
Smith, Reuben Menifee, 1563
Smith, Thomas Caesar, 1465
Smith, Troy, 870
Smythe, Jay Bingham, 657
Snell, N. Russell, 1193
Snow, Frank Simeon, 579
Sodaro, Anthony, 871
Soper, Horace Wendell, 1030
Sours, Burton Osmond, 1193
Sparks, Thomas Plewman Sr., 444
Sprague, Emory Russell, 230
Stahl, Earl J., 503
Stahlman, Frederick C., 444
Staines, Albert G., 1465
Stanbery, Henry, 871
Stansberry, Charles Lee, 1110
Steele, Edson Hun, 967
Steiner, Charles Albert, 655
Steinhauser, Charles Gilbert, 1465
Sterrett, John Kennedy, 1193
Stevens, George Michael, 1193
Stewart, John Noel, 967
Stinson, William David, 1374
Stokes, Merle Leneefiel, 871
Stone, Gordon, 579
Storch, Lewis A. E., 45
Storz, Christian, 1193
Stout, Gurn Thompson, 1110
Strang, David M., 45
Strasner, Thomas J., 1465
Strauss, Fletcher Louis, 1375
Strickler, Albert, 1463
Strickler, Cyrus Warren Sr., 442
Stroup, Paul Eugene, 1465
Stuckman, Edwin D., 503
Stull, Samuel Lewis, 871
Suer, Robert Eugene, 579
Sullivan, Lawrence Francis, 579
Sullivan, Walter Thomas Jr., 1375
Sutton, John Chalmers, 1465
Swayne, Jap F., 1193
Sweet, Charles Frederick, 1465
Sweet, Grover Cleveland, 657
Swift, Homer Fordyce, 967

T

Taber, Martin Emerald, 1193
Taquino, George James, 1030
Tatge, Edward George, 579
Taylor, Herbert William, 871
Taylor, Leland Harris, 1193
Teaford, Schuyler Ferree, 871
Thabes, John Alois, 45
Thomas, Harry V., 1193
Thomas, William, 1193
Thompson, Alvin, 1562
Thompson, Ira Fay, 1030
Thompson, Jesse Eugene, 1563
Thompson, Noah Howard, 657
Thomson, Milton, 1465
Tiernon, Luke Bart, 444
Tillman, William Gilbert, 1193
Tinder, J. Stanley, 657
Tinley, Mary Louise, 230
Tinstman, Abraham Lincoln, 1465
Toomajan, Harry John, 1465
Torpy, Thomas William, 657
Townsend, Junius M., 230
Trigger, Harry W., 1193
Trimbo, Joseph Henry, 1193
Trombley, Bryan, 1375
Truitt, Berton Cleveland, 871
Turchi, John Dominic, 230
Turner, Henry Cromwell, 658
Twohig, John Elmer, 1297
Twyeffort, Louis Hollenback, 579
Tyson, William Elisha Ellicott, 45

U

Uhr, Jacques Stanley, 1297
Ullman, Julius, 230
Ulrich, Julius Hirsch, 1193
Ungard, William Thomas, 1193
Utley, Vernon T., 658
Uzmann, Francis Joseph Jr., 1297

V

Valens, John Douglas, 1297
Vannatta, George Woodruff, 1193
Van Norden, William Erickson, 1465
Van Winkle, Joseph Olin, 1193
Vaught, John Lester, 1465
von Buddenbrock, Erick, 579

W

Wade, Edward H., 658
Waffle, Clara W. Reames, 871
Wagner, Rudolf, 1563
Waide, Arthur, 45
Waldapfel, Richard, 1463
Walker, Alfred Augustus, 160
Walton, Gordon Graham, 579
Walz, Frank Gebhard, 1465
Ward, Harry Norbert, 658
Warfield, Mary Cabell, 1193
Waterbury, D. Elliot, 230
Waters, Donald, 1297
Watkins, Daniel Alvey, 1297
Watkins, Martin Lucius, 1465
Watson, James Alexander, 444
Waufle, Guy Clifford, 1193
Webb, Rollin Edward, 1193
Webb, Roy, 658
Weber, John Joseph, 503
Webster, Albert Martin, 1297
Webster, Margaret E. Burgess, 1297
Wedekind, Robert, 230
Wegrocki, Adolph A., 1193
Weimer, Edgar Stanley, 230
Weiss, Charles, 579
Wellbery, Edward Montgomery, 1297
Wellman, Orand Forrest, 579
Wells, Fred Lloyd, 1108
Wells, James K., 871
Wendell, Thomas T., 1465
West, Harmon, 579
Westphal, Henry Gustave, 1193
Wheaton, Clarence Loyd, 228
Whelan, Edmond Vincent, 1297
Whelan, Edward James, 658
Whipple, Farrington Hasham, 1297
Whitbeck, Sherwood Volkert, 230
White, Eston Delaney, 658
White, Frank Melvin, 658
White, Marvin Spears, 1193
White, Milo Ritter, 444
Wick, William Winfield, 1297
Wiedenman, Charles Edward H., 1297
Wier, Frank Augustus, 45
Wiland, Louis, 1465
Wilcox, John Miller III, 1297
Wilde, Salmon Perry, 1297
Wiley, Bert Earle, 1297
Wilking, Spies Valentine, 579
Wilkins, Howard Francis, 579
Wilkinson, Robert Johnson, 742
Willard, Edgar Harold, 1297
Willey, Ralph, 579
Williams, Aubrey H., 230
Williams, Benjamin Gregory, 444
Williams, James Marcus, 1297
Williams, Samuel Hanson, 658
Williams, Suel Elsworth, 503
Williamson, Charles Hodge, 45
Wilson, Robert Patterson Clark, 230
Wilson, William, 1465
Winter, Louis Carl, 658
Winters, William Thomas, 444
Wirslg, Arnold Oswald, 1465
Woglom, William Henry, 228
Wo ff, Thomas Conrad, 1465
Wolin, David, 44
Wollin, Maurice, 658
Wonderlick, Joseph Anthony, 503
Wood, George Harden, 1465
Woods, Arthur Daniel, 1465
Woolling, Richard H., 444
Worley, John R., 967
Wright, Paul, 45
Wylie, John Thomas, 1465

Y

Yates, Oscar Raymond, 230
Yeo, Gordon Hurst, 1465
Yocum, Boaz, 444
York, Charles E., 230
Young, Albert Frederick, 1465
Young, Richard Hart, 742

Z

Zimmerman, Amelia, 1465
Zimmerman, Henry Samuel, 1465
Zweig, Hedwig, 871

E

E COMPOUND: See Cortisone
EAR: See also Deafness; Hearing; Oto—
bruit in left ear, 1231
diseases, Chandler Ford Fund for research in Mass., 1026
internal, labyrinthic hypotension, Paris, 663
Middle, Infection of: See Otitis Media
neurotoxicity of streptomycin, [Winston] 752—ab
pulse heard in, 990
Ringing in: See Tinnitus
unexplained swellings, 692
EARNINGS: See Wages
ECHINOCOCCOSIS
campaigns against, Chile, 1566
ECLAMPSIA
pathological anatomy, [McKay] 1206—ab
treatment, protoveratrine, [Mellman] *542
ECONOMICS, MEDICAL: See also Insurance, sickness; Medical Service; Medically Indigent
A. M. A. Bureau of Medical Economic Research: See American Medical Association
cost of attending medical school, *130; 148—E
cost of National Health Service, London, 1309
fees, [Business Practice] *1118; *1202; *1309; *1477; *1573
financing hospital to insure independence, England, 1568
medical and health budgets of federal agencies, 1033
office management, [Business Practice] *1045
physician and economist look at old-age and survivors insurance, [Blasingame & Dickinson] *921; 959—E
ECTHYMA
topical treatment with erythromycin, [Livingood & others] *1266
ECZEMA
Contact: See Dermatitis venenata
sensitization, nervous mechanism in [Charpy] 1408—ab
ECZEMA—Continued
treatment, erythromycin locally, [Livingood & others] *1266
treatment, hydrocortisone acetate, [Bourgeois-Cavardin] 1131—ab
vaccination of child with, (replies) [Baldridge; Little] 694
EDEMA: See also Ascites; Elephantiasis; under name of specific organ as Brain
General or Universal, of Newborn: See Erythroblastosis, Fetal
in kwashiorkor, (Council article) [Williams] *1282
of unknown origin, (reply) [Jonas] 1068
unexplained swellings, 692
EDINBURGH
University of: See University
EDUCATION: See also Children, school; Schools
Audiovisual: See Moving Pictures; Television
Higher: See University
television stations, report, 1459
United States Department of Health, Education and Welfare: See United States
EDUCATION, MEDICAL: See also Graduates; Schools, Medical; Students, Medical; University
A. M. A. Annual Congress on, (report) 945
A. M. A. Council on: See American Medical Association
American Medical Education Foundation, 111; (funds disbursed to medical schools) 858; (A. M. A. resolution on) 927; (3rd annual report) 956
Course: See also subheads: Graduate Course; Postgraduate Course; Teaching
course (refresher) for general practitioners, 573; (Texas) *1475
Factbook on, by A. M. A. council, 152
Fellowships: See Fellowships
Financial Support: See Schools, Medical
Graduate: See also subhead: Postgraduate
graduate and postgraduate differentiated (Council report) 941
graduate courses, physicians and graduate students working for advanced degrees 1952-1953 *122; *123
EDUCATION, Medical—Continued
graduate training programs acceptable by American Board of Psychiatry and Neurology, *388
in U. S. and Canada, 53rd annual report by A.M.A., *105; 148—E
Internship: See Interns and Internships
National Defense and Joint Committee on Medical Education in Time of National Emergency, *111
National Fund for Medical Education *111; (report) 942
number, Sept. 12, 1953, page 105
Postgraduate See also Education, Medical, graduate
postgraduate and continuation courses for physicians *133; (to July 1954) 1365—E; *1381
postgraduate course, deducting expense from income tax, Coughlin case, (Bureau report) 837
postgraduate courses in internal medicine, Chile, 970
postgraduate courses in Texas, (Council article) *1475
postgraduate, questionnaire on, 942; 1022—E
postgraduate television clinic, 1458
Premedical See also Basic Sciences
premedical, A. A. A. S. meeting to discuss, 1559
premedical, minimum requirements by A.M.A. Council *128
Residents: Residencies: See Residents and Residencies
Scholarships: See Scholarships
survey by A.M.A. and Association of American Medical Colleges, *106; 149—E; 942
Teaching Institute (first) of Association of American Medical Colleges, 652; 1023—E
teaching material survey on indigent care, (report) 950
teaching of general practice, London, 660
teaching rounds, private beds in, [Armstrong] *82; 149—E
teaching, scheduled clock hours of instruction, *117

EDUCATION, Medical—Continued
training, early development of the psychiatrist; Long memorial Lecture, [Hall] *615
training for general practice, *130
World Conference on, London, Aug. 22-29, 1953, *108; 492—E; 942
EFFORT: See also Exercise
Angina of: See Angina Pectoris
blood pressure reactions to, Chile, 969
EFFUSIONS
malignant, radioactive gold treatment, [Seaman & others] *630, [Walter] 1060—ab
EFOCAINE
death after intercostal use [Angerer & others] *550
EGGS
raw yolk plus X-rays for bone sarcoma in child, [Krebs] 1408—ab
Swift's strained egg yolks for babies, 1099
ELASTIC Stockings: See Hosiery
ELBOW
baseball pitcher's, 74
ELDERLY: See Old Age
ELECTRIC: See also Electro—
Hearing Aids: See Hearing Aids
High Frequency Current: See Diathermy
shock treatment, contraindications, 607
shock treatment, fatal heart rupture, [Malamud] 1578—ab
ELECTROCARDIOGRAM: See Heart
ELECTROCOAGULATION: See Diathermy
ELECTROCOMA: See Electric shock treatment
ELECTROENCEPHALOGRAPHY See Brain
ELECTROLYTES
disturbances in Cushing's syndrome, [Sprague] 449
metabolism in paraplegia, [O'Connell & Gardner] *708
ELECTRONICS
instrumentation, meeting on, 1027
ELECTROSHOCK: See Electric shock
ELECTROTHERAPY: See Electric shock treatment
ELECTROTHERMY: See Diathermy
ELEMENTS
trace, in brucellosis; trace elements added to dairy ration, (Council article) [Berman] *643
ELEPHANTIASIS
nostras, surgical treatment, [Gagliardi] 453—ab
ELIZABETHAN banquet at St. Thomas Hospital (London) to celebrate 400th year of refounding, 583
EMBOLISM: See also Thrombosis
arterial emboli-aortography, [Lovingood] 1205—ab
cavitation within bland pulmonary infarcts, [Soucheray] 755—ab
cerebral, stellate ganglion block of value in stroke? [Ruben & Mayer] *1002
coronary, [Cheng & others] *211
pulmonary, amniotic fluid, [Bacala] 246—ab
pulmonary, "fibrinoclasi" on [Zini] 1592—ab
pulmonary fulminant, is it meteorotropic? [Bertz] 885—ab
Thromboembolism: See Thrombosis
EMBRYO: See also Fetus
rubellar, [Malbran] 886—ab
EMERGENCY: See also First Aid
call plans, (report) 955
calls, "is there a doctor in the house?" Krim Theater, Detroit, 37
calls, new paging system, Wis., 1291
food needs, research on, Minn., 1103
in newborn, [Cooper & others] *1077
infracostal approach in cardiac arrest, [Wexler] 516—ab
lung resection for massive hemoptysis, [Ross] 1578—ab
Medical Service, A.M.A. Council on National Emergency Medical Service: See American Medical Association
medical service, care of casualties in aircraft (hospital plane; helicopter), [White & Merkle] *20
medical service, care of middle meningeal hemorrhage, [Raney & others] *1434
medical service in acute abdominal conditions, Chile, 1111
thoracotomy in spontaneous hemothorax, [Borrie] 764—ab
EMERSON Rocking Bed, Standard Hospital Model, 33
EMOTIONS: See also Anger; Mental Health; Psychosomatic Medicine
effect of isoniazid on, 1524—E
EMPHYSEMA
Heart (cor pulmonale): See Heart hypertrophy
lobar obstructive, in infant, lobectomy in, [Sloan] 758—ab
pulmonary circulation in, internists discuss, Italy, 505
treated by pneumoperitoneum, [Brackenridge] 67—ab
EMPLOYEES; Employment: See Industrial Health
EMPLOYMENT Opportunities for Physicians: See Physicians, positions open
EMPYEMA
cnemotherapy, Finland, 1377
incidence, artificial pneumoperitoneum vs. pneumothorax, [Heaton] 1486—ab
of gallbladder, oxytetracycline for, [Schultz] 1489—ab
pleural, streptokinase-streptodornase in enzymatic decortication, [Halse] 687—ab
thoracic, streptokinase-streptodornase in, [Finberg] 1763—ab
ENCEPHALITIS: See also Encephalomyelitis; Meningoencephalitis; Polioencephalitis
complications of rubella, 258
histopathology of multiple and diffuse sclerosis, [Hallervorden] 1582—ab
infectious, Calif., 1454
outbreak, coxsackie viruses associated with [Stanley] 251—ab
postvaccinal, [Miller] 512—ab; [André-Baillsaux] 1320—ab
toxoplasma, [Weisse] 603—ab
ENCEPHALOMALACIA
treatment, stellate ganglion block [Ruben & Mayer] *1002
ENCEPHALOMENINGITIS: See Meningoencephalitis
ENCEPHALOMYELITIS
transplacental transmission of Western equine type, [Shinefield] 591—ab
ENCEPHALOMYELOPATHY with icterus: See Kernicterus
ENDAMOEBA
histolytica, water contaminated with; boil water for 15 minutes, 1142
Infection: See Amebiasis
trophozoites, "free-living," agglutination by human serum, Brazil, 47
ENDANGIITIS OBLITERANS
as drug allergy, [Schmid] 982—ab
of kidney and hypertension, [Fellmann] 768—ab
ENDOBRONCHIAL TUBE
to increase bacilli in sputum, [Fourestier] 601—ab
ENDOCARDITIS
bacterial, anemia in [Parsons & others] *14
bacterial, antibiotic therapy, [Geraci] 173—ab
bacterial (occult subacute), pancytopenia as sign [Parsons] 881—ab
bacterial, short term combined use of penicillin and dihydrostreptomycin [Geraci] 1577—ab
bacterial subacute, electrocardiography in, [Donzelot] 254—ab
bacterial (subacute healed) in pregnancy [Fedowitz] 753—ab
bacterial subacute, in penicillin-sensitive patient; penicillin combined with chlorprophenpyridamine maleate for, [Beck] *1170
ENDOCRINE GLANDS: See also under names of specific glands
aspects of infertility in men, [Bishop] *534
changes in paraplegia, [O'Connell & Gardner] *710
disorders, diagnostic pneumoperitoneum in, [Kunstadter] 1203—ab
ENDOTRACHEAL Anesthesia: See Anesthesia
ENEMA
barium enema apparatus, for roentgen examination of colon, [Hodges] *1420
ENERGY: See Effort
Atomic: See Atomic Energy
Metabolism: See Metabolism, basal
Ultrasonic: See Ultrasonics
ENGINEERING, human, 722—ab
ENGLAND: See also British
ENLISTED Men or Women: See Armed Forces; Medical Preparedness
ENSILAGE: See Silo
ENTERITIS: See Intestines inflammation
ENURESIS: See Urine, incontinence
ENZODASE: See Hyaluronidase
ENZYMES: See also under specific names as Hyaluronidase; Streptokinase-Streptodornase
"fibrinoclasi" on emboli of pulmonary arteries, [Zini] 1592—ab
Paul-Lewis Laboratories award to enzyme chemist: Dr. Meister, 872
EOSINOPHILIA: See under Eosinophils
EOSINOPHILIC GRANULOMA: See Granuloma
EOSINOPHILS
count (absolute) in diagnosis of neoplasms, [Murray] 63—ab
eosinophilia in childhood caused by visceral larva migrans, [Dent] 683—ab
eosinophilia in infectious hepatitis, Mexico, 507
in hypertension, [Taquini] 70—ab
staining, 7 methods for, 1067
EPIDEMIC JAUNDICE: See Liver Inflammation
EPIDEMIC PAROTITIS: See Mumps
EPIDEMICS: See under names of specific diseases
Prevention: See Immunization; Vaccination
EPIDERMIS: See Skin
EPIDIDYMIS
surgery, epididymovas anastomosis for sterility, [O'Conor] *532
EPILEPSY
center for study of, Italy, 505
cure, research on, 608
diagnosis, electroencephalography in, [Buchthal] 986—ab
etiology and cerebral anoxia [Courville] 679—ab
myoclonus, in diffuse neuronal disease, [Watson] 1120—ab
Physicians' League Against, 608
treatment (correction) 573
treatment, lobotomy, [Freeman] 592—ab
treatment, medical, [Lennox] 986—ab
treatment, paramethadione also trimethadione, nephrotic syndrome during, [Wren & Nutt] *918
treatment, surgical, late results [Guillaume] 768—ab
Village for Epileptics changed to Neuropsychiatric Institute, N. J., 1456
EPINEPHRINE: See also Arterenol (Norepinephrine)
ketosis in diabetes mellitus, [Miller] 1594—ab
treatment of asthma advisable in cardiovascular disease? 1496
treatment, skin response to injection in atopic dermatitis, [Lobitz] 512—ab
EPIPHORA: See Lacrimation
EPITHELIUM: See also Tissues
oral stratified squamous, "field cancerization" in, [Slaughter] 1480—ab
EPITUBERCULOSIS: See Tuberculosis of Lung
EQUIPMENT: See Apparatus
ERB-Goldflam's Disease: See Myasthenia Gravis
ERGOMETER
to study effect of heparin on intermittent claudication, [Simon & Wright] *98; [Collens] 1115—C; (reply) [Simon & Wright] 1115—C
ERUPTIONS: See Herpes; Measles; Rubella; Scarlet Fever
Creeping: See Larva migrans
Industrial: Seen Industrial Dermatoses
ERYTHALGIA: See Erythromelalgia
ERYTHEMA: See Lupus Erythematosus
ERYTHREMIA: See Polycythemia
ERYTHROBLASTOSIS, FETAL
etiology: ABO incompatibility, [Dunn] 448—ab
leuko-erythroblastosis, [Beattie] 1217—ab
prevention, 1232
treatment, exchange transfusion, [Sacks] 1570—C
ERYTHROCIN: See Erythromycin
ERYTHROCYTES
Count: See Anemia, Pernicious; Polycythemia
erythrocytopathia punctata granuliformis (new entity) in adult, [Brugsch] 771—ab
ovalocytosis, (reply) [Lipton] 776
qualitative punctate stippling of, diagnosis of lead poisoning in factory workers, 608
ERYTHROMELALGIA
burning pain in foot in woman 82 years of age, 693
ERYTHROMYCIN (Erythrocin; Ilotycin)
[Mathieu de Fossey] 71—ab
treatment (local) of cutaneous bacterial infections, [Livingood & others] *1266
treatment of nonbacterial respiratory infections, [Jones & others] *262
treatment of pyoderma, [Freeman] 245—ab
ERYTHROPLASIA OF QUEYRAT
[Merricks] 172—ab; (case report) [Friedman] 173—ab
ESKIMOS
Canadian, poliomyelitis in, [Wood] 598—ab
ESOMID: See Hexamethonium
ESOPHAGOLARYNGECTOMY: See Esophagus cancer
ESOPHAGUS
burning sensation in, after gastrectomy, 1597
cancer, in elderly, esophagolaryngectomy (Wookey operation) for, [Lam & Gordon] *552
cysts, [Totten] 246—ab
dental foreign bodies in, 35—E
Fistula: See Fistula
Hiatus Hernia: See Hernia, diaphragmatic
in general practice (spasm; diverticula, etc.), [Thorek] *703
obstruction due to Serutan; relief with liquid Taka-diastase, [Johnson] 235—C
roentgen study, limitation, [Swenson & Jeffrey] *1425
rupture of aortic aneurysm into [Calenda & Uricchio] *548; [Baer] 1571—C
substitution with isoperistalic colon, [Dogliotti] 1488—ab
tumors (benign), [Totten] 246—ab
varices (bleeding), sign of hypertension in child, [Mithoefer] *1097
varices (bleeding), surgical treatment, [Linton] 168—ab; 1124—ab
varices (bleeding), various methods of treatment, 1286—E

ESOPHAGUS—Continued
varices, gastrointestinal hemorrhage from, [Palmer] 519—ab
varices (portal hypertension), [Thorek] *704
ESSAY
Contest for: See Prizes
ESTRIFOL, N.N.R., (Premo) 1447
ESTROGENS:
conjugated, N.N.R., (Premo) 1447
Diethylstilbestrol: See Diethylstilbestrol
excretion in women with breast cancer before and after adrenalectomy, [Dao] 761—ab
metabolism, role of liver in, [Mayer] 1584—ab
treatment combined with androgens, Italy, 1468
treatment of menopausal symptoms, 456
treatment of prostate cancer, [Fergusson] 67—ab; [Francese] 599—ab; [Mortensen] 766—ab
treatment of trichomoniasis vaginalis, [Candiana] 1131—ab
treatment plus orchiectomy in prostate cancer, [Holder] 885—ab
treatment plus thyroid extract in prostate cancer, [Bornmann] 1059—ab
ETHAVERINE
treatment of angina pectoris: daily report cards employed, [Voyles & others] *12
ETHICS, MEDICAL: See also Privileged Communications
determining the fee, [Business Practice] *1118; *1202; *1309; *1477; *1573
oath of Hippocrates, reproduced 733
of psychiatry and clinical psychology, Belgium, 660
private practice in small industry, [Rieke] *198
what Philadelphia physicians tell patients with cancer, [Fitts & Ravdin] *901; [Bowen] 1570—C
ETHINYL ESTRADIOL
N.N.R., (Chemo Puro) 727
ETHYL BISCOUMACETATE (Tromexan)
treatment controlled by Owren's method in thromboembolism, [Lund] 602—ab
ETHYL IODOPHENYLUNDECYLATE (Pantopaque)
fatal late meningeal reaction to, [Erickson & van Baaren] *636
N.N.R., (Lafayette Pharmacal) 727
ETHYLISM: See Alcohol
dl-ETHYLSTILBESTROL: See Diethylstilbestrol
ETHYL VANILLATE
treatment of blastomycosis, [Stillians & Klemptner] *560
EVACUATION
of casualties in aircraft (hospital plane; helicopter), [White & Merkle] *20
EVEREST
climbed, London, 972
EVIDENCE: See Medicolegal Abstracts at end of letter M
EXAMINATION: See American Board; Basic Sciences; Licensure; National Board of Medical Examiners
Physical: See Physical Examination
EXCHANGE Transfusion: See Blood Transfusion
EXERCISE: See also Athletics; Effort
effect on electrocardiograms and ballistocardiograms, [Davis] 1478—ab
Master Two-Step Exercise Test: See Heart function
therapeutic, value in peripheral arterial disease, [Wisham & others] *10
tolerance test, myocardial infarction, 693
EXHIBIT: See also Health museum; Medicine, history; Physicians, avocations
A.M.A. Bureau of: See American Medical Association
A.M.A. Scientific Exhibit: See American Medical Association
medical, London, 1027
EXOPHTHALMIC GOITER: See Goiter, Toxic
EXOPHTHALMOS: See Goiter, Toxic
EXPANDEX: See Dextran
EXPECTORATION: See Sputum
EXPERIMENTATION: See Animal Experimentation; Research
EXPLOSIONS
Atomic: See Atomic Energy
Hazard: See Anesthesia
EX-SERVICE Men: See Veterans
EXTRASYSTOLES: See Arrhythmia
EXTREMITIES: See Arms; Foot; Legs
Amputation: See Amputation
Blood Supply: See Blood Vessels disease (peripheral); Raynaud's Disease
Burning Pain in: See Erythromelalgia
Cramps: See Cramps
Paralysis: See Hemiplegia; Paraplegia
EYEBROWS
shaving of, 1142
EYELIDS
vaccinia of; aureomycin used in second case, [King & Forrest] *31
EYES: See also Blindness; Ophthalmology; Vision
Accommodation: See Night Blindness
bank donations, Ga., 435
color, anthropological tests of paternity, Sweden, 49
Disease: See also Cataract; Conjunctivitis; Glaucoma
disease, nasal sinusitis as focus of infection in [Weille] 1121—ab
disease, oxygen supply in, [Bietti] 56—ab
epiphora: what causes eyes to water? 608
hyperophthalmopathic Graves' disease, [Hedges] 1574—ab
irritants, turpentine and isopropyl alcohol, 455
muscles, localized myasthenia gravis, [Grob] *530
ophthalmic ointments, use in industrial practice, 1416
ophthalmic solutions, clinical value of pH in, [Floyd] 590—ab
paralysis (exophthalmic), [Millikan] 585—ab
Retrolental Fibroplasia: See Retrolental Fibroplasia
Rodenstock Refractometer, 645
tuberculosis, first sanatorium devoted to its treatment in Great Britain, 445
vitreous hemorrhage of unknown origin, 692
EYESIGHT: See Vision

F

F COMPOUND: See Hydrocortisone
FACE: See also Jaws; Mouth; Nose
Cream: See Cosmetics
flushing in woman, 1497
granuloma (lethal), corticotropin in, [Hagens] 165—ab
numbness in acoustic nerve tumors, [Cleveland] 1579—ab
ultraviolet therapy (prolonged) for acne of, injurious? 776
FACTOR U: See Blood
FACTORY: See Industrial Health; etc.
FACULTY: See Schools, Medical
FAHR Lecture: See Lectures
FAINTING: See Syncope
FALLOPIAN TUBES: See Oviducts
FAMILIES: See Children; Infants; Maternity; Paternity
FAMILY PHYSICIANS: See Physicians, practicing
FARM: See also Farmers; Rural Communities
accidents, 34—E
Animals: See Animals
leaders, A. M. A. conference of, 1367
FARMERS
chest pain from exposure to soil dust in, [Williamson] 164—C
lung, [Studdert] 524—ab
protecting from poisonous dusts, containing organic mercury compounds, 1161—ab
FASCIA: See Contracture, Dupuytren's; Tendons
FAT: See also Lipids; Obesity
balance test in intestinal malabsorption, [Girdwood] 765—ab
headache in diabetic after eating, 894
in Feces: See Feces
meals high in, vagotomy effect on gastric evacuation of, [Waddell] 61—ab
Subcutaneous, Disease of: See Panniculitis
FATHER: See Paternity
FATIGUE
effect on poliomyelitis in mice, [Rosenbaum] 1484—ab
tired and nervous patients, 991
FAUST, ERNEST CARROLL, portrait, La., 1454
FECES
Blood in: See Melena
fat in; blood pressure in steatorrhea, [de Langen] 1324—ab
Loose Stools: See Diarrhea; Dysentery
FECUNDATION: See Impregnation, artificial
FECUNDITY: See Fertility
FEDERAL: See United States
Civil Defense Administration: See Civilian Defense
Government: See United States government
Income Tax: See Tax
Legislation: See Laws and Legislation, federal
Security Agency: See Health, U. S. P. H. S.
FEE: See Fees
FEEBLEMINDED: See Idiocy
FEED for Livestock: See Animals
FEEDING: See Diet; Food
Infant's: See Infants
FEES: See also Wages
adjustment of, [Business Practice] *1309
determining the fee, [Business Practice] *1118; (8 rules) *1202
discussion with patients, [Business Practice] *1477
private practice in small industry, [Rieke] *198
to help the patient pay, [Business Practice] *1573
Tuition: See Basic Sciences; Schools, Medical
FEET: See Foot
FELDMAN-Sabin Dye Test: See Toxoplasmosis
FELLOWSHIPS: See also Scholarships
Albert, established, N. Y., 154
American Academy of Pediatrics, 1371
American Cancer Society, 223
American Gastroenterology Assn., in gastroenterology available, 651
American Trudeau Society, in tuberculosis research, 572
Arthritis and Rheumatism Foundation, 39
Drummond, research in nutrition, London, 874
Illinois Trucking Industry, 1368
in medicolegal pathology, Md., 1455
in pediatric neurology, available in Levinson research foundation, Chicago, 1027
in statistics at University of Chicago, Ill., 1288
Life Insurance Medical Research Fund, predoctoral, 651
list of, according to specialties, A. M. A. Council report, *311
National Foundation for Infantile Paralysis, 438
National Research Council, applications open, 439
National Science Foundation, 580; 1187
to promote advancement of science throughout the world, [Trimble] *1146
U. S. Atomic Energy Commission, in industrial medicine, 1298
FELONS: See Paronychia
FEMUR
fractures of neck of, "unsolved" problems and complications, [McCarroll] *536
FERRIC: Ferrous: See Iron
FERTILITY: See also Impregnation; Spermatozoa; Sterility
A. M. A. Section on Urology symposium on, [O'Conor] *532; [Bishop] *534
FERTILIZATION: See Impregnation
FETAL ERYTHROBLASTOSIS: See Erythroblastosis
FETUS: See also Embryo; Infants, Newborn; Placenta; Pregnancy
abnormalities in those exposed in utero to atomic bomb detonation, 218—E
asphyxia, and its treatment, [Holtz] 767—ab
bishydroxycoumarin therapy during pregnancy effect on, 1142
Death of: See also Stillbirth
death of, during labor, from intrauterine anoxia, [Taylor] 522—ab
Erythroblastosis: See Erythroblastosis, Fetal
heart murmur (loud): fumic or umbilical souffle, 991
intrauterine perforation of Meckel's diverticulum, [Rosza] 240—ab
Premature: See Infants, premature
Rh factor in: See Rh Factor
roentgen rays used during pregnancy, 218—E
Supreme Court (Nebraska) held that unborn child is part of its mother until birth, (Bureau report) 839
transplacental transmission of encephalomyelitis, [Shinefield] 591—ab
FEVER: See also Rheumatic Fever; Scarlet Fever
Canicola: See Leptospirosis
Cerebrospinal: See Meningitis, cerebrospinal
Glandular: See Mononucleosis, Infectious
leukemia with, 1415
Malta: See Brucellosis
Q: See Q Fever
Relapsing: See Relapsing Fever
Therapeutic: See Malaria, therapeutic
Undulant: See Brucellosis
FIBRIN
postpartum hemorrhages from fibrinogen deficiency, [Vecchietti] 1591—ab
"FIBRINOCLASIS"
on emboli of pulmonary arteries, [Zini] 1592—ab
FIBRINOGEN: See Fibrin
FIBRINOLYSIN
Streptococcic (streptokinase): See Streptokinase-Streptodornase
FIBROMYXOMA
extraosseous, simultaneously with fibrous dysplasia, [Braunwarth] 524—ab
FIBROPLASIA
Retrolental: See Retrolental Fibroplasia
FIBROSARCOMA
congenital, in mastoid region, [Hartz] 1127—ab
FIBROSIS
dysplasia (Jaffé-Lichtenstein), [Braunwarth] 524—ab
of sphincter of Oddi, [Cattell] 213—ab; 516—ab
FIGHTING: See Boxing; War
FILMS: See Moving Pictures
FINGERS: See also Hand; Toes
black discoloration beneath gold rings, 455; (reply) [Brauer] 1416
mallet, new splint for, [Spigelman] *1362
FIRE: See also Burns
hazards in hospitals, Wis., 438
FIREARMS
prevention of accidents from, 1365—E

V 15
195

FIRST AID: See also Emergency
instructions to meet household emergencies, Los Angeles County Medical Ass'n, 647—E
techniques, American Red Cross adopts changes in, 1106
FISH
Heinz Strained Cream of Tuna, 1099
FISH SKIN: See Ichthyosis
FISSURES
anal (recurrent), pathogenesis; treatment, [Kratzer] *1165
FISTULA
esophagorespiratory, Brazil, 1564
vesicointestinal, in regional ileitis, [Robinson] 597—ab
FITS: See Convulsions
FITZ, REGINALD, council memorial to, 946
FLEMING, Sir ALEXANDER (1881 ——)
Shattuck lecture: pharmacology of penicillin, 94—ab
FLIES: See Larva
FLIGHT: See Aviation
FLOORING
cement and radiant-heated, health hazard? 1414
conductive, for operating rooms to guard against explosions, 608
wooden vs. concrete floors in gymnasium, 893
FLORIDA
respiratory infections in, relation to citrus fruit, 527
University of: See University
FLOUR: See Bread; Grain
FLOWERS: See also Gardens
hobby, [Leisure Corner] *55
"FLU": See Influenza
FLUIDS: See also Milk; Water
accumulation in malignancies retarded with radioactive gold, [Seaman & others] *630
Body: See Cerebrospinal Fluid
FLUKES: See Distomiasis; Schistosomiasis
FLUORINE
dental caries and, [Amies] 1323—ab
endemic dental fluorosis in Kenya, [Williamson] 1128—ab
Fluoridation of Water Supply: See Water supply
skeletal fluorosis, spinal compression due to, [Murthi] 983—ab
FLUSHING
of face and neck of woman, 1497
FLYERS; Flying: See Aviation
FOG: See Smog
FOLIC ACID: See Acid, folic
FOLLICULITIS
pustular, topical erythromycin for, [Livingood & others] *1266
FOOD: See also Bread; Cheese; Diet; Fish; Fruit; Meat; Milk; Nutrition
A. M. A. Council on Foods and Nutrition: See American Medical Association
artificial sweeteners in, London, 1039; 1378
Balls: See Bezoar
Canned: See Infants, feeding
Cooking: See Cooking
emergency needs, research on, Minn., 1103
for Livestock: See Animals
Infants, feeding
Ingestion of: See Indigestion
products, chemicals in, Delaney House committee on, [Seevers] *1331
solid, supplement to improve nutrition of children, [Spies] *185
supply, available in Chile, 1566
U. S. Food and Drug Administration, toxicity of chemicals, [Seevers] *1330
Vitamins in: See Vitamins
FOOT: See also Ankle; Orthopedics; Toes
burning pain in woman 82 years of age, 693
clubfoot, 1430—ab
hyperkeratosis affecting, [Dencer] 1058—ab
preventing fungus infections, 1068
shoes affect form of, [Knowles] 69—ab
sweating from radiant-heated floors, 1414
FOOTBALL
advisable for high school boys with defective vision, 892
FOOTWEAR: See Hosiery; Shoes
FORCEPS
Obstetric: See Labor
FORD (Chandler) Fund: See Foundations
FORD (Edsel B.) Lecture: See Lectures
FORD Foundation: See Foundations
FOREIGN BODIES: See also Stomach: Uterus
dental, in lung and esophagus, 35—E
FOREIGN COUNTRIES: See also under names of specific countries as India; Israel; Korea
Christian Medical Council for Overseas Work, [Fenan] 1114—C
Graduates from: See Physicians, foreign
Medical Schools in: See Schools, Medical
opportunities and responsibilities of physician in world affairs, [Trimble] *1143
today's medicine in underdeveloped areas, [Bowers] *1167
Physicians from: See Physicians, foreign
FORENSIC Medicine: See Medical Jurisprudence
FORMALDEHYDE
examination of tissue sections, (replies) [Wright; Pickard] 1328
FORTIPHONE Hearing Aid, Model 20 A; Model 21 C, (report) 1021
FOUNDATIONS
American Foundation for Allergic Diseases, organized, 1105
American Medical Education Foundation, *111; (funds disbursed to medical schools) 858; (A. M. A. resolution on) 927; (3rd annual report) 956
Arthritis and Rheumatism, (fellowships for basic research), 39
Dohney (Estell) Eye Foundation, fourth lecture, Calif., 864
Ford (Chandler), 1026
Ford, (medicine in underdeveloped areas) [Bowers] *1167; (Fund for Adult Education) 1459
Grancher, 50th anniversary, 49
Imperial Cancer Research Fund, London, 1568
Kellogg (W. K.), 37; (grant to U. of Louisville), 435, (postgraduate television clinics) 1458
Kresge, grant to National Multiple Sclerosis Society, 1105
Lasdon, grants by, 651
Levinson, fellowship in pediatric neurology, 1027
Life Insurance Medical Research Fund, predoctoral fellowships by, 651
Markle (John and Mary R.), (fund for teachers and investigators) 571
National Foundation for Infantile Paralysis, (fellowships from), 438
National Fund for Medical Education, *111; 942
National Science, (offers graduate science fellowships), 580; 1187; (scientific translations center established), 659
Nutrition Foundation, Inc., (Osborne and Mendel award), 1187
Pfeiffer (Louis) Research, 1558
Prize: See Prizes, American Association of Obstetricians, Gynecologists and Abdominal Surgeons
Rockefeller, (report), 571
Runyon (Damon) Memorial Fund grants, 1106; 1292
deVilliers, leukemia award, 1290
Volker (William) Fund supplements research grants of A. M. A. Committee, 35—E; 934
FOWLER'S Solution: See Potassium arsenite
FRACTURES: See also Orthopedics; under names of specific bones
asymptomatic, in osteoporotic spines of aged, [Gershon-Cohen & others] *625
course on, Colorado, 734
exhibit at A. M. A. St. Louis Clinical Meeting, 494
treatment, allergic contact dermatitis from Medmac, [Conrad & Ford] *557
treatment, Küntscher's method of nailing, [Weyand] 1226—ab
treatment, Principles of Fracture Reduction (film review), 1308
treatment, solution for "unsolved fracture" been found? [McCarroll] *536
FRAGILITAS OSSIUM
osteogenesis imperfecta with dentinogenesis imperfecta, [Toto] 247—ab
FRANCE: See French
FRANKLYN, ROBERT ALAN, surgical activities of bolstering bosoms, 1200—BI
FREEZING: See Frostbite
FRENCH
Congress of Medicine at Paris, Oct. 15-17, 1953, 41
Congress of Otorhinolaryngology, 41
Medical Days, 1460
Speaking Countries, Medical Congress of, 1293
FRESHMEN Students: See Students, Medical
FRIDERICHSEN-Waterhouse Syndrome: See Waterhouse
FRIEDENWALD
Lecture: See Lectures
Medal: See Prizes
FRIEDMAN TEST
what conditions other than pregnancy will cause positive results? 1229
FRIEDREICH'S Ataxia: See Ataxia
FRIGIDITY
treatment, androgens, Italy, 1468
FROG Test: See Pregnancy, diagnosis
FROSTBITE
treatment, sympathectomy, [Isaacson] 249—ab
FRUCTOSE (Levugen)
N. N. R. (description) 274; (Mead Johnson) 274
name accepted by Council, 801
FRUIT: See also under specific names as Dates; Orange
citrus, relation to respiratory infections, 527
FULBRIGHT AWARDS
offered, 438
FUMAGILLIN
treatment of amebiasis, leukopenia after, [Malewitz] *1446
FUNDS: See Foundations
FUNGI: See Yeast
infection with: See Mycosis
FUNGICIDES
protecting farmer from poisonous dusts containing mercury compounds, 1161—ab
FUNNEL CHEST: See Thorax
FURAZOLIDONE (Furoxone)
name accepted by Council, 801
FUROXONE: See Furazolidone
FURUNCULOSIS
treatment, topical erythromycin, [Livingood & others] *1266

G

G. I. BILL OF RIGHTS
for Korean War veterans, *117
GADE INSTITUTE
standardization of serologic tests for syphilis, Norway, 663
GAERTNER, ERASTO, death, 225
GAIT: See Claudication
GALLBLADDER: See also Bile Ducts; Biliary Tract
absence (congenital), Brazil, 1299
absence (congenital) diagnosed at operative cholangiography, [Malmström] 1485—ab
calculi, angina-like pains, 1328
cancer, statistics, [Cooke] 1586—ab
disease, patterns of pain in, 629—ab
empyema, oxytetracycline in [Schultz] 1489—ab
in left upper quadrant, Brazil, 1195
inflammation, incidence of papilloma with cancer, [Tabah] 521—ab
roentgen study in infants, Priodax or Telepaque orally for, [Harris & Caffey] *1333
roentgen study, pseudoalbuminuria after, [Holoubek & others] *1018
GALLSTONES: See Gallbladder, calculi
GAMMA
Benzene Hexachloride: See Benzene Hexachloride, gamma
Globulin: See Globulin
GANGLION (nerve)
stellate, block of value in stroke? [Ruben & Mayer] *1002
stellate, block, vs. corticotropin and cortisone for shoulder-hand syndrome, [Steinbrocked & others] *788
GARDENS
flowering hobby, [Leisure Corner] *55
hospital, London, 747
GAS: See Carbon Dioxide; Oxygen
GASTRECTOMY: See Peptic Ulcer, surgical treatment; Stomach, surgery
GASTRIC: See Stomach
Juice: See Stomach secretion
Ulcer: See Peptic Ulcer
GASTROENTEROCOLITIS
staphylococcic, after giving antibiotics, [Terplan] 1481—ab
GASTROENTEROLOGY
Argentina Congress (2nd) of, 162
fellowship in, 651
National Congress of, Colombia, 1037
GASTROENTEROSTOMY
vagotomy for ulcer recurring after, [Walter & Chance] *993
GASTROINTESTINAL TRACT: See also Abdomen; Digestive System; Duodenum; Indigestion; Intestines; Stomach
disorder in kwashiorkor, (Council article) [Williams] *1283
disorders and flying, 643—ab
hemorrhage from esophageal varices, [Palmer] 519—ab
hemorrhage from rupture of aortic aneurysm into esophagus, [Calenda & Uricchio] *548; [Baer] 1571—C
motility, effect of anticholinergic drugs, [Ruffin & others] *1160
roentgen examination, A. M. A. Section symposium on [Hodges] *1417; [Swenson & Jeffrey] *1422; [Sommer & Goodrich] *1424; [Glanturco & Miller] *1429; [Golden & Morales] *1431
roentgen examination, limitations, [Swenson & Jeffrey] *1422
GASTROSCOPY: See Stomach
GEE-HERTER'S Disease: See Celiac Disease
GELATIN
film, absorbable (Gelfilm), name accepted by Council, 801
film, absorbable (Gelfilm) N.N.R., (description) 1174; (Upjohn) 1174
GELFILM: See Gelatin film
GENERAL PRACTICE: Practitioner: See Medicine, practice; Physicians, practicing
GENERAL REGISTER OFFICE
analyzes records of general practitioners, London, 1469
GENITALS: See Gonads; Penis; Vagina
GEOGRAPHY
residence of freshman students, *124; *126; *127; *128
GEORGIA
blood sugar findings, [McLoughlin & others] *182
GERBER'S Junior Prunes, 1099
GERIATRICS: See Old Age
GERM CELL: See Chromosomes
GERMAN
Institute of Pharmacology (20th), 41

GERMAN MEASLES: See Rubella
GERMICIDES: See Antisepsis; Sterilization, Bacterial
GERMS: See Bacteria
GESTATION: See Pregnancy
GESTOSIS: See Pregnancy, toxemia of
GIDDINESS: See Vertigo
GIFTS: See Donations (cross reference)
GILLES DE LA TOURETTE'S DISEASE (reply) [Yap] 528
GLANDS: See under names of specific glands of Internal Secretion: See Endocrine Glands
Sex: See Gonads
GLANDULAR FEVER: See Mononucleosis, Infectious
GLASGOW
University of: See University
GLAUCOMA
causes of blindness in England, 1469
course on, N. Y., 37
GLOBINE-OXYDASE
oxygenation of hemoglobin, Paris, 877
GLOBULIN
gamma, allocation for mumps in adult males and for preventing German measles (rubella) in early pregnancy, 74
gamma, in therapy, [Lamarca] 767—ab
gamma, limitations in preventing poliomyelitis, [Hammon] 752—ab
gamma, problem of immunologic agranulocytosis, [Hansen] 67—ab
Immune: See Immune
value vs. total protein in multiple myeloma, 1598
GLOMERULONEPHRITIS: See Nephritis, glomerular
GLUCAGON
hyperglycemic glycogenolytic factor of pancreas, [de Duve] 887—ab
GLUCOCORTICOIDS
hydrocortisone and resistance of tissue to injury, [Nettleship] 1040—C
GLUCOSE
danger from mixing stored blood and dextrose solutions, 1597
in sodium chloride and citrated whole blood given simultaneously, (reply) [Gibson] 258
insulin tolerance tests, interdependence efforts of stress and adrenal cortex [Burns] 979—ab
tolerance test, symptoms after gastrectomy, 1068
treatment of pain from potassium intoxication in Kimmelstiel-Wilson syndrome, [James & others] *545
GLUTATHIONE
symposium on, 1106
GLYCEMIA: See Blood sugar; Diabetes Mellitus
GLYCERYL TRINITRATE
effects on attacks of pain in angina pectoris, [Voyles & others] *12
evaluate coronary vasodilators, [Russek & others] *207
treatment of myocardial infarction, 693
used to study vasospasm, [Foley] 168—ab
GLYCOBIARSOL (Bismuth glycolylarsanilate; Milibis)
name accepted by Council, 801
GLYCOSURIA: See also Diabetes Mellitus
renal, 664; [Fox] 682—ab
renal, progress into diabetes mellitus? [Rohers] 1585—ab
GLYCYRRHIZA
licorice juice in treatment of ulcer, [Carpetti] 1219—ab
GLYOXYLIDE
Koch's cancer cure, 647—E; 665—BI
GOECKERMAN Treatment: See Arthritis, psoriatic
GOETSCH vitamin T in care of newborn and premature infants, [Schmidt] 1585—ab
GOITER: See also Goiter, Toxic; Hyperthyroidism
adenolipomatosis as new type of [Chesky] 521—ab
iodine prophylaxis and iodine deficiency, [Wespi] 176—ab
GOITER, TOXIC
complications: diabetes, Paris, 664
hyperophthalmopathic, [Hedges] 1574—ab
needle biopsy of liver in, [Movitt] 237—ab
neuromuscular disease relation to, [Millikan] 585—ab
surgical aspects of thyrotoxic heart disease, [Schlicke] 884—ab
treatment, subtotal thyroidectomy, follow-up after [Dollerup] 1324—ab
GOLD
dermatitis, treatment with cortisone, [Den Oudsten] 888—ab
radioactive, treatment of malignant effusions, [Seamen & others] *630; [Walter] 1060—ab
radioactive, treatment of prostate cancer, [Kerr] 240—ab
ring, finger discolored beneath, 455; (reply) [Brauer] 1416
treatment, complications: effects of splenectomy and BAL, [Watson] 686—ab
GOLDBERGER Award: See Prizes
GONADS: See also Ovary; Testes
aspects of infertility in men, [Bishop] *534
Turner's syndrome, (in female), [Jackson] 1217—ab; (in male) [Sougin-Mibasham] 1217—ab
GOUGH, LOUIS K., Commander of American Legion, A. M. A. resolution on remarks by, (report) 829
GOUT
ammonia, urea, and uric acid in, [Bolliger] 1582—ab
lecture on, Mo., 1289
treatment, sodium salicylate, [Marson] 1590—ab
treatment, toxic effects of phenylbutazone, [Nassim] 524—ab
GOVERNMENT: See United States
Hospitals: See Hospitals, veterans
GRADES
scholastic record of 1952-1953 freshman class, *129
GRADUATE
Courses: See Education, Medical
Fellowships: See Fellowships
GRADUATES: See also Interns and Internships; Residents and Residencies
Foreign: See Physicians, foreign
in approved schools, 1910-1953, *119
statistics on, *118
with baccalaureate degrees in medical schools *120
working for advanced degrees, 1952-1953, *122; *123
GRAFT: See Aorta; Skin
GRAIN: See also Bread; Corn
disability from inhaling dust from, [Cohen] 61—ab
GRANCHER Foundation: See Foundations
GRAND MAL: See Epilepsy
GRANTS for Research: See American Medical Association; Fellowships; Foundation; Research; University
GRANULOCYTOPENIA: See Agranulocytosis
GRANULOMA
amebic, in large intestine, Brazil, 745
amebic, of rectum simulates cancer, [Ernst] 1056—ab
beryllium, of skin; nonsurgical treatment, [Fisher] 1119—ab
eosinophilic, of skin, Brazil, 969
Malignum: See Hodgkin's Disease
of nose and face, corticotropin in, [Hagens] 165—ab
rheumatic, pathogenesis [von Albertini] 1491—ab
Venereum: See Lymphogranuloma, Venereal
GRAVES' Disease: See Goiter, Toxic
GRAVITY: See Specific Gravity
GREAT BRITAIN: See British
GREAT VESSELS, Transportation of: See Heart anomalies
GREECE
appointments for physicians who visit, [Maugum] 973—C
GREENWELL, J. L., A. M. A. General Practitioner's Award to, (biographical sketch; portrait) 1366—E; 1526; (Dr. Greenwell's remarks of acceptance) 1526
GRID
Wetzel, analysis for 2 undernourished children, [Spies] *187
GRIEVANCE Committee: See Societies, Medical
GRIP: See Influenza
Devil's: See Pleurodynia, Epidemic
GROSS, L., filtrable agent causing mouse salivary gland carcinoma, 150—E
GROUP
Hospital Insurance: See Hospitals, expense insurance
therapy with the chronically ill, [Koven] 1479—ab
GROWTH
effect on nutritional processes, [Spies] *185
methylandrostenediol effect on, [Netter] 1592—ab
of the child, 9—ab
retarded, in kwashiorkor, (Council article) [Williams] *1282
GUIDANCE: See Counseling
GUILLAIN-BARRÉ SYNDROME
epidural space in [Antoni] 689—ab
GUMS: See also Jaws; Teeth
herpes simplex infections, [Buddingh] 520—ab
GUNS: See Firearms
GYMNASIUM: See Athletics
GYNECOLOGY
American Board of: See American Board
androgen therapy in, Italy, 1468
national meeting of Colombian gynecologists, 1037

H

HADASSAH Medical School: See Hebrew University
HAIR
excessive, hirsutism during pregnancy, 1497
HAIR—Continued
excessive, hypertrichosis, in hyperadrenocorticalism, Italy, 1468
excessive, hypertrichosis in tuberculous meningitis, [Cetrángolo] 1219—ab
Loss of: See Alopecia
oily, in white women, treatment, 607
HALLUX Valgus: See Toes
HAND: See also Fingers; Wrist
affected by hyperkeratosis, [Dencer] 1058—ab
burn with acetylene blowtorch, 1415
Left Handedness; See Left Handedness
nodules in tendons of, 258
shoulder syndrome, sympathetic block vs. corticotropin and cortisone therapy, [Steinbrocker & others] *788
surgery of, symposium, Ohio, 865
HANDICAPPED: See also Blindness; Crippled children, conference on, Ky., 649
Rehabilitation: See Rehabilitation
state housing for, N. Y., 1104
HANSEN'S Disease: See Leprosy
HANSENOSIS
suggest as term for leprosy, [Feldman] 1041—C
HAPTENS
Rh: See Rh Factor
HARVARD Lecture: See Lectures
HARVEY Lecture: See Lectures
HAUSWIRTH Lecture: See Lectures
HAY FEVER
asthma after: all-year round vs. preseasonal desensitization; corticotropin or cortisone treatment 1066
HEAD: See also Brain; Cranium; Face; Neck
Bald: See Alopecia
Enlargement: See Hydrocephalus
injuries, emergency care of middle meningeal hemorrhage, [Raney & others] *1434
HEADACHE: See also Migraine
hypertension and, [Stewart] 687—ab
in diabetic after eating fats, 894
HEALING: See Wounds
HEALTH: See also Disease; Sanitation
A.M.A. Committee on Relations between Medicine and Allied Health Agencies, Dr. McCormick's statement, 730
American Public Health Ass'n., (meeting) 965
budgets of federal agencies, 1033
Center: See also Medical Center
center, Beit Mazmil Community, Israel, 746
centers (union), study of, (report) 951
commissioner (deputy): Dr. Heeren, Iowa, 221
conditions and mass immigration, Israel, 231
control for older persons, [Kountz] *777
Council appointed, Ill., 36
department (public) and family physician, [Getting] *265
Education, A. M. A. Bureau of: See American Medical Association
education in India, [Bowers] *1167
Examination: See Physical Examination
foreign health workers, conference of, 161
forums, Ind., 495
Health and Fitness Consultants, (Bureau report) 853
Home Council, A. M. A. Council report, 834
Industrial: See Industrial Health
Insurance: See Insurance, sickness; Medicolegal Abstracts at end of letter M
International Health Organization: See World Health Organization
Mental: See Mental Health
museum, A.M.A. assistance to, (Bureau report) 846
National Health Service (England): See National Health Service
National Institutes of, lecture by Dr. Corl, 580
officer, and natal day deaths, [Bundesen] *166
President's Commission on the Health Needs of the Nation: See President's Commission
public, American Association of Public Health Physicians organized, 573
public health laboratory (new), S. C. 1458
public, scholarship fund memorializing Dr. Manning, Nebraska, 1103
public, Seoul National University School of, emergency library for, 1184
Rural: See Rural Communities
Service: See Medical Service
Statistics: See Vital Statistics
U. S. Department of Health, Education and Welfare: See United States
USPHS, (study of amyotrophic lateral sclerosis) 659; (chemotherapy of miliary tuberculosis and tuberculous meningitis) 769—ab; (regular corps examination for medical officers) 744; 1035; (participated in health program of 20 foreign countries) [Trimble] *1146; (contracts to abate water pollution) 1194; (new international vaccination certificate) 1194
Units: See Health center; Medical Center
Workers: See Health, foreign health workers
World Health Organization: See World Health Organization

V 15
1957

HEARING: See also Ear
Aids: See Hearing Aids *following*
Center (Henry C. Barkhorn Memorial) N. J., 569
Loss of: See Deafness
problems in industry, Wis., 39
HEARING AIDS
Fortiphone, Model 20 A; 21G 1021
Transistor, (Council report) 491
HEART: See also Arteries, coronary; Pericardium
American Heart Association, (grants-in-aid) 156
Anomalies: See also Ductus Arteriosus, patent
anomalies, atrio-septo-pexy for interatrial septal defects, [Bailey] 980—ab
anomalies, closure of interauricular septal defects, [Björk] 1315—ab
anomalies, complete transposition of great vessels, [Lillehei] 1402—ab
anomalies (congenital), familial incidence, [McKeown] 1057—ab
anomalies, features of interatrial defect, [Chapman] 1400—ab
anomalies, surgical correction of atrial septal defects, [Neptune] 246—ab
arrest and ventricular fibrillation: experimental study, [Stewart] 586—ab
arrest, emergency infracostal approach in [Wexler] 516—ab
arrest in infants and children, [Snyder] 586—ab
arrest, intracardiac puncture in, [Cronkhite] 593—ab
Arrhythmia: See Arrhythmia
Aschoff bodies in auricular appendages in mitral stenosis, [Decker] 1122—ab; [McNeely] 1209—ab
Aschoff nodules in rheumatic granuloma, [von Albertini] 1491—ab
association organized, Alaska, 1371
Atrial Fibrillation: See Atrial Fibrillation
Atrial Flutter: See Atrial Flutter
auscultation (objective), new device for, [Briskier] 258—ab
Beat, premature: See Arrhythmia, extrasystoles
block, bundle branch, [Lundh] 175—ab
block, use of thyroid extract in Adams-Stokes syndrome, 776
cancer (metastatic), incidence; clinical signs, [Bisel & others] *712
catheterization in acquired valvular defects, [Bayer] 1219—ab
catheterization in chronic pulmonary conditions, [Divry] 1126—ab
Chilean Society of Cardiology, bulletin of, 1112
Cleveland poster art contest, Ohio, 650
College of Cardiology meets in Cleveland, Nov. 6-7, 964
consultation clinic, Mo., 154
course in cardiology, Wis., 497
Disease: See also Cardiovascular Disease; Endocarditis; Pericarditis
disease and family physician, climate and iatrogenic aspects, [Mills] *910
disease, beriberi, [Benchimol] 879—ab
disease, cause of death in physicians, [Poynton] 1379—C
disease, choice of anesthesia in, 786—ab
Disease (Congenital): See Heart anomalies
Disease (Coronary): See Arteries, coronary
disease, detect salt depletion during therapy with mercurial diuretics, [Silverman] 64—ab
disease, effect of Valsalva maneuver on circulation, [Ellisberg] 169—ab
disease, federal grant for teaching at George Washington University, 1183
Disease (Hypertensive): See Blood Pressure, High
disease in chronic arsenic poisoning, [Robbins] 1316—ab
disease, incidence and types, [Hutcheson] 1479—ab
disease, Institute on, Iowa, 1026
disease, multivalvular, and simultaneous surgical correction, [Bolton] 756—ab
disease, occupational potentialities of older patients, [Bronstein] 169—ab
disease, principles and practice of prognosis, (Billings Lecture) [White] *75
Disease (Pulmonary) (Cor pulmonale): See Heart hypertrophy
disease (rheumatic) and cor pulmonale, [Taquini] 984—ab
disease (rheumatic), cortisone for, [Ballabio] 1491—ab
disease (rheumatic) incidence, effect of cortisone therapy, [Johnson] 63—ab
disease, sclerotherapy for variocose veins contraindicated in? 1141
disease, symposium on, (Calif.) 648; 734; (Wash.) 866
disease (thyrotoxic), surgical aspects, [Schlicke] 884—ab
disease, vocational counseling for children with, N. Y., 1456
electrocardiogram, effects of exercise and smoking, [Davis] 1478—ab
HEART—Continued
electrocardiogram in coronary embolism, [Cheng & others] *211
electrocardiogram in spontaneous auricular flutter, [Prinzmetal & others] *553
electrocardiogram (nonspecific) in coronary disease, [Levine] 1312—ab
electrocardiogram, skin resistance encountered in making of, 893
electrocardiographic interpretation, course in, Ill., 1556
electrocardiographic tests of coronary vasodilator drugs, [Russek & others] *207
electrocardiography and roentgenographic findings, compared in I^{131} induced myxedema, [Kurland] 1052—ab
electrocardiography in subacuate infectious endocarditis, [Donzelot] 254—ab
Emphysema (Cor pulmonale): See Heart hypertrophy
Enlargement: See Heart hypertrophy
Failure: See Heart insufficiency
function during altitude stress, [Marbarger] 1401—ab
function, Master 2-step exercise test of coronary vasodilator drugs, [Russek & others] *207
gastrocardiac syndromes, Italy, 232
hyperactive carotid sinus reflex of cardioinhibitory type, [Soloff] 1205—ab
hypertrophy, cor pulmonale, [Taquini] 984—ab
Infarction: See Myocardium
Inflammation: See also Endocarditis; Pericarditis
inflammation (rheumatic), corticotropin for, short-term use, [Wilson] 1046—ab
insufficiency, intravenous digitalization, 1496
insufficiency, myxedema heart; advanced failure with rapid recovery [Weyher] *639
lesions in poliomyelitis, [Georg] 770—ab
Murmurs: See also Heart sounds
murmurs, apical and aortic systolic, [White] 57—ab
murmurs, loud fetal, 991
Muscle: See Myocarditis; Myocardium
National Advisory Heart Council, (appointments) 580
New York Heart Association, use of term "atrium" for "auricle" [Hyman] 1304—C
Output: See Blood circulation; Blood volume
Pain: See Angina Pectoris
pumping action of, and its valves, new AMA exhibit, 1024
puncture (intracardiac) in cardiac arrest, [Cronkhite] 593—ab
Rate: See Pulse
rehabilitation program at West Point, N. Y., 436
rehabilitation, symposium on, N. Y., 569
research grant by Central Ohio Heart Association, 496
resuscitation from ventricular fibrillation, [Wegria] 680—ab
Rhythm: See Arrhythmia
roentgen study in (I^{131}) radioactive iodine induced myxedema, [Kurland] 1052—ab
rupture (fatal) during electroshock treatment, [Malamud] 1578—ab
Size: See also Heart hypertrophy
size, external measurement, 1230
Sounds: See also Heart murmurs
sounds, systolic "clicks", 258
surgery, atrio-septo-pexy for interatrial septal defects, [Bailey] 980—ab
Surgery, Commissurotomy: See Aortic Valve; Mitral Valve
surgery (open) by direct vision, during hypothermia, [Swan & others] *1081
surgery, spontaneous auricular flutter observed during, with high speed color cinematographs and electrocardiograms, [Prinzmetal & others] *553
symposium at Brooke Army Hospital, 580
teaching day, N. Y., 736
Valves: See also Aortic Valve; Mitral Valve; Pulmonary Valve
valves, cardiac catheterization in with acquired defects, [Bayer] 1219—ab
vectorcardiography, 992
Ventricular Fibrillation: See Ventricular Fibrillation
wounds, penetrating 1011—ab
HEAT: See also Burns; Cooking; Fire
boiling water for 15 minutes to kill Endamoeba histolytica, 1142
dry, bacterial sterilization by, 1327
Production: See Metabolism, basal
Therapeutic Use: See Diathermy; Ultrasonics
HEATING
radiant heated floors cause excessive sweating of feet, 1414
HEBERDEN'S NODES
hereditary aspects, [Stecher] 166—ab
HEBREW UNIVERSITY
Hadassah Medical School, American Students for, Israel, 231
Hadassah Medical School, medical library at, Israel, 231
Hadassah Medical School, new depts. of plastic surgery and psychiatry, Israel, 746
HEINE-Medin Disease: See Poliomyelitis
HEINZ PRODUCTS
Junior Macaroni and Cheese, 1521
Strained Cream of Tuna, 1099
Strained Rice and Cheese, 1521
HELMINTHIASIS: See Teniasis
HEMANGIOMA
nevi, conservative treatment, [Wallace] 1058—ab
HEMATEMESIS
rupture of aortic aneurysm into esophagus, [Calenda & Uricchio] *548 [Baer] 1571—C
HEMATOCRIT
hemoglobin response of blood donors, [Cole] 591—ab
HEMATOLOGY: See Blood
HEMATURIA
causes of, [Lee & Davis] *782
HEMILAMINECTOMY: See Neurons
HEMIPLEGIA
pain in hemiplegic area, 1416
treatment, corrective brace for upper extremity [Rudin & others] *479
treatment, mephenesin, [Rigoletti] 68—ab
HEMISPHERECTOMY: See Brain surgery
HEMOGLOBIN
concentration in bacterial endocarditis, [Parsons & others] *14
oxygenation of: "globine-oxydase," Paris, 877
response of blood donors, [Cole] 591—ab
HEMOLYSIS: See also Anemia, hemolytic
Disease in Newborn: See Erythroblastosis, Fetal
fatal transfusion reaction from blood factor U, [Wiener & others] *1444
intravascular, [Monroe] 1319—ab
HEMOPHILIA
Antihemophilic Plasma (Human): See Antihemophilic Plasma
like disease after pregnancy, [Frick] 517—ab
HEMOPTYSIS
massive; emergency lung resection for, [Ross] 1578—ab
periodic loss of voice, 606
HEMORRHAGE: See also Hemophilia; Purpura; under names of specific organs and regions as Brain; Gastrointestinal Tract
due to self-medication with bishydroxycoumarin, [Cosgriff] *547
during anticoagulant therapy, [MacMillan] 1584—ab
Menstrual: See Menstruation
physical role of platelets in arresting hemorrhage, [Zucker] 1041—C
postpartum, from fibrinogen deficiency, [Kyriakis] 1591—ab
Subarachnoid: See Meninges
tendency to, effect of bishydroxycoumarin therapy during pregnancy, 1142
treatment, platelet transfusion in postirradiation hemorrhagic state, [Woods] 242—ab
HEMOTHERAPY: See also Blood Transfusion
spinal injection of blood to lower blood pressure, [Helmark] 592—ab
use of human blood, 1496
whole blood with glucose in sodium chloride given simultaneously, (reply) [Gibson] 258
HEMOTHORAX
spontaneous, emergency thoracotomy in, [Borrie] 764—ab
HENDERSON, ELMER L.
letter from American Hospital Association on his death, 733
HENNEMAN'S modification of Randolph's method for staining eosinophils, 1067
HEPARIN
coronary vasodilators evaluated, [Russek & others] *207
treatment of angina pectoris, [Donzelot] 254—ab
treatment of arteritis of lower limbs, [Remy] 1130—ab
treatment of intermittent claudication, ergometric study, [Simon & Wright] *98; [Collens] 1115—C; (reply) [Simon & Wright] 1115—C
treatment of venous thrombosis, [Artz] 1048—ab
treatment, Owren's method to control, in thromboembolism, [Lund] 602—ab
HEPATIC: See Liver
HEPATITIS: See Medicolegal Abstract at end of Letter M
Infectious: See Liver Inflammation
HEPATOLENTICULAR Degeneration: See Lenticular Nucleus
HEPATOLITHIASIS: See Liver calculi
HEREDITY
aspects of Heberden's nodes, [Stecher] 166—ab
factors in development of cancer, Paris, 664
ichthyosis simplex, 775
ovalocytosis, (reply) [Lipton] 776
HERMAPHRODITISM
chromosomal sex detected from skin biopsy, [Moore] 65—ab
pseudohermaphroditism (male), testicular feminization in, [Morris] 515—ab
HERNIA
diaphragmatic, emergency in newborn, [Cooper & others] *1077
diaphragmatic hiatus, angina-like pain, 1328
inguinal, in men over 55, [Debenham] 882—ab

HERNIA—Continued
inguinal (left) involving ovary, tube and uterus [Torres Oliver] 1216—ab
inguinal, pathogenesis, Brazil, 969
of Intervertebral Disk, of Nucleus Pulposus: See Spine, intervertebral disk
of Meninges: See Meningocele
HEROES
Volunteers to Aid Research: See Research
War: See Korean War
HERPES
simplex infections, [Buddingh] 520—ab
zoster, no specific therapy, 1415
zoster, pathogenesis, [Cheatham] 677—ab
zoster, treatment for chronic neuralgia after, 456
zoster, treatment with influenza virus vaccine, [Griswold] 1404-ab
HETRAZAN: See Diethylcarbamazine
HEXACHLOROPHENE
N.N.R., (Bowman) 1447
HEXAMETHONIUM (Bismitrium; Esomid; Methium)
bromide, N.N.R., (description) 924; (Squibb) 925
chloride in hypertension, [Hirshleifer] 64—ab
chloride, N.N.R., (Chemo Puro) 727; (Burroughs) 1363; (Ciba) 1447
induced hypotension, liver and kidney function in, [Schweizer] 1213—ab
treatment of hypertension, [Hilker & others] *5; [Bartorelli] 1321—ab
treatment, parenteral, in hypertension, [Morrison] 524—ab
HIATUS Hernia: See Hernia, diaphragmatic
HIBERNATION
Artificial: See Narcosis
HIGH
Altitude: See Altitude
Blood Pressure: See Blood Pressure, High
Frequency Apparatus: See Diathermy
Frequency Sound: See Ultrasonics
HIGHWAY Accidents: See Automobiles, accidents
HILL-Burton Act: See Hospitals, building
HINKLEMAN'S method for staining eosinophils, 1067
HIP: See also Femur
arthroplasty, indications, technique, prognosis [Westeroorn] 175—ab
dislocation (congenital), late results of treatment, [Muller] 1220—ab
intermittent claudication of, 791—ab
HIPPOCRATES
oath of, reproduced, 733
HIRSCHSPRUNG'S Disease: See Colon, megacolon
HIRSUTISM: See Hair, excessive
HISTAMINE
Antihistamine: See Antihistamines
treatment plus nicotinic acid in aged, [Levy] *1260
HISTOLOGY: See also Cells; Epithelium; Tissues
presuppose physician's knowledge of, in medical writing, [Torelvia] 1380—C
HISTOPLASMIN
testing in Philippine tuberculosis hospital, [Halde] 754—ab
HISTOPLASMOSIS
clinical, in Pennsylvania, [Charr] 594—ab
epidemics [Grayston] 515—ab; [Furcolow] 1207—ab
focalized pulmonary, surgical consideration in, [Forsee] 980—ab
HISTORY
medicine and warfare, [Fulton] *482
of Medicine: See Medicine, history
HOARSENESS
periodic loss of voice, 606
HOBBIES: See Leisure Corner; Physicians, avocations
HODGKIN'S DISEASE
complicating pregnancy, Irradiation for, [Kaplan] 64—ab
treatment: roentgen therapy, cortisone, nitrogen mustard, 774
HOGS: See Trichinosis
HOLLANDER TEST
symptoms following gastrectomy, 1068
HOME
Accidents: See Accidents, home
Flooring for: See Flooring
nursing homes, standardization, [Murdock] *1442
spraying house with DDT to control leishmaniasis, Brazil, 1299
Treatment: See Self-Medication
wheelchair, for veterans, grants for, 968
HOME LIFE: See Journals
HOMICIDE: See Murder
HOMOGRAFT: Aorta, surgery
HOOVER MEDICAL TASK FORCE
on medical service, members of, 1298
HORDER, THOMAS JEEVES, 1st baron
general practitioner and lay education in cancer, 1377
HORMONES: See also Endocrine Glands; under names of specific glands as Adrenals; Medicolegal Abstracts at end of letter M
injection treatment of no value in azoospermia [Weisman] 694
HORMONES—Continued
regulation of dentition, [Baume] 768—ab
Sex: See Androgens; Estrogens
therapy breast cancer after, [Emerson] 680—ab
HOSIERY
Are Elastic for Men, 1285
HOSPITALIZATION INSURANCE: See Hospitals, expense insurance
HOSPITALS: See also Sanatorium (cross reference); Medicolegal Abstracts at end of letter M
Accreditation: See Hospitals, registered
Administrators: See also Hospitals, psychiatric
administrators (federal), 7th Inter-Agency Institute for, 46
A.M.A. Council on Medical Education and Hospitals: See American Medical Association
A.M.A. Division of, (report) 942
Approved by A.M.A.: See Hospitals registered
Army, Brooke symposium on cardiac arrest, 580
Army, 46th Surgical Army Hospital in Korea, 1466
Army, new interns at Tripler, (photo) 872
autopsy rates highest, 1952-1953, (Council report) *279
bed capacity, internships by medical school affiliation and, *276; *277
bed capacity, number of residencies by, (Council report) *281
beds, private, in medical teaching, [Armstrong] *82; 149—E
Blue Cross Plans: See Hospitals expense insurance
building, 10 to be built by mine workers, 438
Building Program: See also Hospitals, veterans; and various subheads under Hospitals
building program, applications for, under Hill-Burton Act, 161
building program, Hill-Burton Act, (Council report) 949
Children's Hospital in Mexico City, 10th anniversary, 234
communication systems, 893
Coney Island Municipal, 192 million dollar program, N. Y., 1369
consultants, meeting for, 1559
control, plea for decentralization, London, 1567
control, residencies by type of, (Council report) *280; *281
diabetic services, regional planning, London, 661
Expense Insurance: See also Insurance, sickness
expense insurance, Committee on Prepayment Medical and Hospital Service, (report) 953
expense insurance, Commonwealth scheme, Australia, 231
fire hazards in, Wis., 438
Government: See Hospitals, Army; Hospitals, Naval; Hospitals, veterans
Group Hospitalization: See Hospitals, expense insurance
Highland View Cuyahoga County Hospital, (photo) 1457
independence, financing to insure, London, 1568
Insurance: See Hospitals, expense insurance
Interns; Internships: See Interns and Internships
Johns Hopkins, surgery for breast cancer, 1935-1940, [Lewison & others] *905
Joint Commission on Accreditation of, (report) 944; 1448—E
King Edward's Hospital Fund for London, 747
Knickerbocker, Silkworth Memorial Service, New York, 1558
Maine General, outbreak of homologous serum hepatitis from human thrombin, [Porter & others] *17
Massachusetts General, beryllium poisoning registry at, [Hardy] 509—C
maternity, deliveries in, or at home, Sweden, 49
maternity dept., spread of Staphylococcus aureus in, [Barber] 1323—ab
maternity, Hospital Care of Newborn Infants, American Academy of Pediatrics' manual, [Clifford] *473
maternity, prevention of neonatal mortality, [Letourneau] *476
medical motion pictures and projection equipment, survey on use, (Committee report) 847
Medical Service Plans: See Hospitals, expense insurance
Memorial (Sheridan County, Wyo.), laboratory guides used in poliomyelitis, [Varga] 50—C
Naval, at Chelsea, (photo), 744
Neuropsychiatric: See Hospitals, psychiatric
Nurses; Nursing: See Nurses and Nursing
Operating Room: See Surgery
patients, hypercholesteremia in, [Schaefer] 513—ab
personnel shortage, 872
personnel, skin sensitization to antibiotics in, London, 583
HOSPITALS—Continued
physicians pay per cent of fees for using hospital, 829
physician relationship, Council report, 948
physicians relationship inadequate, B. M. A. survey, England, 1195
Physicians relationships, Joint Committee on, report, President's page, 433
plane, helicopters; evacuation and care of casualties, [White & Merkle] *20
poliomyelitis treatment in, London, 748
Presbyterian (Philadelphia), "Information for Patients" booklet, 647—E
psychiatric, American Psychiatric Assn. to certify administrators, 1559
psychiatric, annual report, London, 661
psychiatric, drug treatment of aged patients in state mental hospital, [Levy] *1260
psychiatric, Mental Hospital Institute, 651
psychiatric services in general hospital, [Osborn] *259
Queen's, surgical wing, Hawaii, 156
radiology practice in and by, opinion of Ohio's attorney general, (Bureau report) 838
registered by A. M. A., additional list, 1572
registered by A. M. A. and internships, 1943-1953, (Council report) *276
registered by A. M. A. for residency training, list of, (Council report) *275
registered, inspection by A. M. A., (Council report) 945
registered, Joint Commission on Accreditation of Hospitals, report, 944; 1448—E
Residents; Residencies: See Residents and Residencies
St. Joseph, Ariz., (photo) 1025
St. Thomas, 400th anniversary of refounding (1553-1953), London, 583
service A. M. A. Section of, activities, (report) 944
Service Plans: See Hospitals, expense insurance
service, priority for war pensioners, London, 1378
standardization of nursing homes, [Murdock] *1442
State: See Hospitals, psychiatric
Survey and Construction Act: See Hospitals, building program
Swan, at Cambridge (Ohio), 436
veterans, and non-VA, average daily patient load, 872
veterans, 5-year follow up on streptomycin treated tuberculosis, [Smith] 514—ab
veterans, hospitalization entitlement of veterans, (Committee report) 836
veterans new, dedicated in West Haven, 659
veterans, new managers, 161
Veterans, Residencies in: See Residents and Residencies
Vina del Mar, Chile, acute abdomen conditions seen in emergency service, 1111
HOSTELS: See Tourists Camps, Hostels, etc.
HOUSE: See Home
Committee: See United States Congress of Delegates: See American Medical Association
HOWE (William) Award: See Prizes
HYALURONIDASE
in renal lithiasis, [Tinnaci] 1592—ab
in traumatic surgery, [Mac Ausland] 1314—ab
N. N. R., (Enzodase of Squibb) 1363
HYDATID DISEASE: See Echinococcosis
HYDATIDIFORM Mole: See Placenta tumors
HYDERGINE
treatment of congenital hyperhidrosis, [Carson] 1212—ab
treatment of hypertension, [Wilbrandt] 166—ab
HYDRALAZINE (Apresoline)
treatment of hypertension, [Hilker & others] *5; [Grob] 1123—ab
treatment plus sodium restriction in hypertension, [Gill] 1205—ab
HYDRAZIDES
Isonicotine: See Inroniazid; Isoniazid; Isonicotinic Acid Hydrazides
HYDROCEPHALUS
treatment, divert spinal fluid into ureter, [Matson] 1483—ab
HYDROCORTISONE (Hydrocortone)
acetate, locally in eczema and pruritus, [Bourgeois-Cavardin] 1131—ab
acetate, N. N. R., (Merck) 1363
resistance of tissue to injury, [Nettleship] 1040—C
treatment, local injection in arthritis, [Ramsey] 759—ab
treatment of nephrotic states, [Luetscher & others] *1236
treatment of rheumatic conditions, [Rubens-Duval] 888—ab
HYDROCORTONE: See Hydrocortisone
HYDROGEN
sulfide, odor of swimming pool water, 178
HYDROGEN ION CONCENTRATION
of ophthalmic solutions, clinical importance, [Floyd] 590—ab
of semen and vagina, relation to conception, [Tyler] *1331
HYDROPHOBIA: See Rabies

V 15
1953

HYDROPS Fetalis: See Erythroblastosis, Fetal
HYDROXYCOUMARIN
Methylene bis: See Bishydroxycoumarin
HYGEIA (Today's Health): See American Medical Association, *Today's Health*
HYGIENE: See Health; Sanitation
Industrial: See Industrial Hygiene
Mental: See Mental Health
HYMENOLEPIASIS: See Teniasis
HYPERADRENOCORTICALISM: See Adrenals cortex
HYPERCALCEMIA: See Blood calcium
HYPERCHOLESTEREMIA: See Blood cholesterol
HYPEREMESIS Gravidarum: See Pregnancy, vomiting in
HYPERGLYCEMIA: See Blood sugar
HYPERHIDROSIS: See Sweat
HYPERKALIEMIA: See Blood potassium
HYPERKERATOSIS: See Keratosis
HYPERPOTASSEMIA: See Blood potassium
HYPERSENSITIVITY: See Allergy
HYPERTENSION: See Blood Pressure, High
HYPERTHYROIDISM: See also Goiter
diagnosis questioned? thyroidectomy indicated? 1598
neuromuscular disease relation to, [Millikan] 585—ab
treatment, radioactive Iodine, [Tubiana] 690—ab; [Costa] 1588—ab
HYPERTRICHOSIS: See Hair, excessive
HYPERTROPHIC ARTHRITIS: See Joints, degenerative joint disease
HYPERTROPHY: See Heart
HYPOALBUMINEMIA: See Blood proteins
HYPOGLYCEMIA: See Blood sugar
HYPOKALEMIA: See Blood potassium
HYPOPHYSECTOMY: See Pituitary, surgery
HYPOPHYSIS: See Pituitary
HYPOPOTASSEMIA: See Blood potassium
HYPOPROTHROMBINEMIA: See Blood prothrombin
HYPOSENSITIZATION: See Allergy
HYPOTENSION: See Blood Pressure, low
HYPOTHALMUS
hydrochloric acid secretion, [Porter] 249—ab
HYPOTHERMIA: See Cold, therapeutic use
HYPOTHYROIDISM: See also Cretinism; Myxedema
neuromuscular disease relation to, [Millikan] 585—ab
radioiodine uptake in, [Silverman] 1483—ab
HYPOVITAMINOSIS: See Vitamins deficiencies

I

I^{131}: See Iodine, radioactive
IBM MACHINE
Section, (Bureau report) 845; 926
ICE
crushed, sanitation of: bacteria count controlled with chlorine solution, 1101—E
ICHTHYOSIS
simplex, inheritance of, 775
ICTERUS
Encephalomyelopathy with: See Kernicterus
IDIOCY
amaurotic (Tay-Sachs disease), 894
IDIOSYNCRASY: See Allergy
ILEITIS
acute and chronic bacillary dysentery and, [Felsen & Wolarsky] *1069; [Palmer] 1199—C
regional (Crohn's disease), vesicointestinal fistula in, [Robinson] 597—ab
ILEOSTOMY
for ulcerative colitis, [Bacon & Trimpi] *1249
ILEUM
roentgen examination in organic diseases, [Golden & Morales] *1431
terminal, radiologic study in typhoid, Chile, 970
ILLEGAL Operation: See Abortion, criminal
Practitioner: See Quackery
ILLINOIS: See also Chicago
placement of physicians in, (Council report) 651; 1522—E
Trucking Industry Fellowships: See Fellowships
University of: See University
ILLNESS: See Disease
Insurance covering: See Insurance, sickness
Time lost because of: See Industrial Health workers absenteeism
ILLUSTRATION: See Art; Photography
ILOTYCIN: See Erythromycin
IMMIGRANT Physicians: See Physicians, foreign
IMMIGRATION
mass, and health conditions, Israel, 231
medical problems of, in Israel, 971
IMMUNE GLOBULIN
safety with respect to hepatitis, [Murray] 1055—ab
IMMUNITY: See also Antibodies; under names of specific diseases
symposium on, Calif., 734
IMMUNIZATION: See also Vaccination; under specific diseases as Diphtheria; Tetanus; Tuberculosis; Whooping Cough
IMMUNIZATION—Continued
A.M.A. exhibits, St. Louis Clinical Session, 434
injection, ulcerative pharyngitis in infant after, 1230
National Immunization Week, 225
postinoculation poliomyelitis, London, 506; [Geffen] 687—ab
sterile abscess after, 1067
IMPERIAL Cancer Research Fund, new laboratories, London, 1568
IMPETIGO
treatment, erythromycin locally [Livingood & others] *1266
IMPOSTERS: See Malingering; Quackery
IMPOTENCE
in diabetics, its mechanism, prognosis, treatment, 1066
IMPREGNATION: See also Coitus; Pregnancy
artificial insemination, for and against; law proposed, Norway, 876
artificial insemination, therapeutic effects, [Tyler] *1354
physiological and clinical aspects of conception, [Tyler] *1351
Preventing: See Contraception
INCOME: See Fees; Wages
Tax: See Tax, income
INCONTINENCE: See Urine
INCOORDINATION: See Ataxia
INCUBATORS
Infanair, Model 500, 645
INDEMNITY
Insurance: See Medicolegal Abstracts at end of letter M
INDEX
Medicus: See American Medical Association, Quarterly Cumulative Index Medicus
INDIA
otolaryngologist wanted in, 439
today's medicine in [Bowers] *1167
treatment of rectal prolapse, (reply), [Chitambar] 694
INDIANS, AMERICAN
wars, physicians in, plaque dedicated to, Ohio, 436
INDIGENT: See Medically Indigent
INDIGESTION
nervous, (reply) [Reeves] 776
Severe Chronic Intestinal: See Celiac Disease
INDUSTRIAL ABSENTEEISM: See Industrial Health workers
INDUSTRIAL ACCIDENTS: See also Workmen's Compensation
burn of hand with acetylene blowtorch, 1415
farm, 34—E
fatalities attributed to boxing, 455
statistics in National Safety Council's annual report, 571
INDUSTRIAL DERMATOSES
skin sensitization to antibiotics in medical personnel, London, 583
INDUSTRIAL DISEASES: See also Industrial Dermatoses; Workmen's Compensation
anticholinesterase poisoning [Moseley] 1318—ab
asthma and odors of paint, 258
baseball "pitcher's elbow," 74
berylliosis, [DeNardi] 675—ab
beryllium poisoning registry, [Hardy] 509—C
brucellosis, caseation necrosis in [Crow] 241—ab
brucellosis in 2 veterinarians, [Spink & Thompson] *1162; 1176—E
caisson disease, 1006—ab
carbon tetrachloride odor in drafting room, 1231
chromate hazards (Council article) [Walsh] *1305
chromoblastomycosis, [Barwasser] *556
dry cleaning agents, hazard of, 1232
farmers, chest pain from exposure to soil dust, [Williamson] 164—C
farmer's lung, [Studdert] 524—ab
grain dust inhalation, disability from, [Cohen] 61—ab
intestinal schistosomiasis, Brazil, 1565
lead exposure, porphyria in, [Shiels] 1488—ab
lead poisoning in factory workers, 608
mercury poisoning, 909—ab
mercury poisonous dusts in fungicides as hazard to farmer, 1161—ab
Pneumonoconiosis: See Pneumonoconiosis
Silicosis: See Pneumonoconiosis
tuberculosis in shoemakers, London, 233; [Stewart] 982—ab
uranium mines, hazard of working in, 692
vibrating tools, hazard, 1327
zinc chloride powder, irritation from, 1141
INDUSTRIAL HAZARD: See Industrial Diseases
INDUSTRIAL HEALTH: See also Industrial Hygiene
A.M.A. Council on Industrial Health: See American Medical Association
conference (Houston) 223; (Minneapolis) 439
councils in communities (report), 833
course in radiological safety, N. Y., 38
hearing problems in Industry, Wis., 39
Institute of, Mich., 650
medical service by private practitioners, [Rieke] *138; [Hughes] *1438
INDUSTRIAL HEALTH—Continued
medical service for workers, Joint Committee report, 951
medical service, use of ophthalmic ointments, 1416
medicine, fellowships in, by U. S. Atomic Energy Commission, 1298
medicine program, Ohio, 1026
mine workers to build 10 hospitals, 438
Minnesota Academy of Occupational Medicine and Surgery organized, 1103
noise in Industry [Walmer] 60—ab
occupational potentialities of older cardiac patient, [Bronstein] 169—ab
small plant program, (Council report) 833
workers absenteeism due to sickness, (Council report) 834
workers absenteeism in radiation workers, [Turner] 1216—ab
workers, longevity in wage earners, 652
INDUSTRIAL HYGIENE
hygienists meet in Pittsburgh, 1027
protecting worker exposed to chemicals, 914—ab
radiation protection comes of age, [Chamberlain] *188
Slough experiment in, London, 972
INDUSTRIAL INJURIES: See Industrial Accidents
INDUSTRIAL POISONING: See Industrial Dermatoses; Industrial Diseases
INDUSTRIAL TRADE UNIONS
study of union health centers, (report) 951
INEBRIETY: See Alcoholism
INFANTAIR, Model 1500, 645
INFANTILE PARALYSIS: See Poliomyelitis
INFANTILISM
Intestinal: See Celiac Disease
Renal: See Osteodystrophy, renal
INFANTS: See also Children; Infants, Newborn; Pediatrics; under names of specific diseases
care provisions for servicemen's dependents, (Council article) [Carter & others] *51
emphysema (lobar obstructive), lobectomy in, [Sloan] 758—ab
feeding, Baby Care: Feeding (film review), 1117
feeding, Beech-Nut Junior Sweet Potatoes, 1099
feeding, breast-feeding in Oxford survey, [Stewart] 1127—ab
feeding, convulsions from SMA formula (Council report) 939; 1521
feeding, Gerber's Junior Prunes, 1099
feeding, Heinz Junior Macaroni and Cheese; also Strained Rice and Cheese, 1521
feeding, Heinz Strained Cream of Tuna, 1099
feeding, prevent allergic disease in newborn by withholding cow's milk from diet, [Glaser & Johnstone] *620
feeding, Swift's Strained Egg Yolks for Babies, 1099
Hospitals for: See Hospitals, children's
Mortality: See also Infants, premature
mortality, falling, Sweden, 1198
mortality, long-neglected field: natal day deaths, [Bundesen] *466
mortality of newborn, prevention and hospitals, [Letourneau] *476
mortality of new-born, role of pediatrician in preventing, [Clifford] *473
mortality, sudden death, [Nevius] 593—ab; 1428—ab
premature, causes of death in, [Rolfsen] 1130—ab
Premature, Retrolental Fibroplasia: See Retrolental Fibroplasia
premature, vitamin T (Goetsch) for, [Schmidt] 1585—ab
pylorospasm, methantheline in, [Levy] 245—ab
surgery: lung resection, [Crossett] 1580—ab
Test-Tube: See Impregnation, artificial
Wilms' tumor in, 1597
INFANTS, NEWBORN: See also Fetus; Placenta
allergic disease in, prevented by withholding cow's milk from diet, [Glaser & Johnstone] *620
Birth Process: See Labor
bishydroxycoumarin therapy during pregnancy effect on, 1142
blood typing for transfusions, 527
care of newborn of diabetic mother, (replies) [Levitt; Fischer] 528; [Tolstoi & others] *1000
dangers of marking-ink, London, 875
emergencies in, [Cooper & others] *1077
Erythroblastosis: See Erythroblastosis, Fetal
incubator for, Infantair, Model 500, 645
Mortality: See Fetus death; Infants, mortality; Stillbirth
neurotoxic conditions, artificial hibernation in, England, 1197
perforated duodenal ulcer in, surgical treatment, [Lichtenstein & others] *557
prognosis for, at time of arrest of progress in labor, [McCain & others] *695
ulcerative pharyngitis in, after immunization injection, 1230
vitamin T (Goetsch) for, [Schmidt] 1585—ab

INFARCTION: See Myocardium
INFECTION: See also Immunity; Staphylococcus; Streptococcus; under specific organs and regions
bacterial, yeast fraction protects against, [Parfentjev] 1381—ab
cortisone encourages, International symposium reports, 1467
of Blood: See Meningococcemia
Prevention: See Antisepsis; Sterilization, Bacterial
remissions in leukemia after, [Bierman] 60—ab
surgical, antibiotics to control, [Meleney & Johnson] *1233
thrombin as vehicle of, in homologous serum hepatitis: outbreak in Maine General Hospital, [Porter & others] *17
treatment, carbomycin, [Hewitt] 1053—ab
treatment, corticotropin, cortisone, and antibiotics, [Kinsell] 684—ab
INFECTIOUS DISEASE: See under names of specific diseases as Measles
Preventing: See Immunization; Vaccination
symposium on, Calif., 1288
INFECTIOUS HEPATITIS: See Liver Inflammation
INFECTIOUS MONONUCLEOSIS: See Mononucleosis, Infectious
INFECTIOUS NEURONITIS: See Guillain-Barré Syndrome
INFERTILITY: See Sterility
INFLAMMATION: See also under names of specific diseases and organs as Gallbladder; Heart; Keratitis; Phlebitis
hydrocortisone and resistance of tissue to injury, [Nettleship] 1049—C
severest surgical, oxytetracycline in, [Schultz] 1389—ab
INFLUENZA
epidemic of 1952-53 in Rome area, [Balducci] 689—ab
symposium on issued by WHO, 855—E
treatment, antibiotics, [Jones & others] *262
vaccination by U. S. Army, 1194
virus vaccine in herpes zoster, [Griswold] 1404—ab
INFUSIONS: See Injections
INHALATION: See Carbon Dioxide; Trypsin
of Dust: See Pneumonoconiosis
INHERITANCE: See Heredity
INHIBIN
x-hormone, second testes hormone described by McCullagh, [Bishop] *534
INJECTION: See also under names of specific substances
intracerebral, of procaine hydrochloride, for obsessive-compulsive reaction, [Myers & others] *1015
intraperitoneal vs. subcutaneous, of cortisone, [Greenspan] 518—ab
Intravenous: See also Anesthesia, intravenous; Blood Transfusion
Intravenous digitalization, 1496
Intravenous, of blood proteins of cattle in man, [Grüning] 981—ab
intravenous, of meperidine hydrochloride before gastroscopy, [Cimoch & Wirts] *1004
Spinal: See also Anesthesia, spinal
spinal, of blood to lower blood pressure, [Heimark] 592—ab
INJURIES: See Accidents; Burns; Fractures; Trauma; under specific organ or region
Industrial: See Industrial Accidents
INK
marking, dangers of, London, 875
INOCULATION: See Immunization; Vaccination
INSANE ASYLUMS: See Hospitals, psychiatric
INSANITY: See Dementia Precox; Mental Disorders; Psychiatry
INSECTICIDES
DDT: See Chlorophenothane
Parathion: See Parathion
toxicity: anti-cholinesterase, [Moseley] 1318—ab
toxicity: chlordane, [Dadey & Kamer] *723
toxicity: hazard of gamma benzene hexachloride, 992
INSECTS: See also Beetles
control classes, of U. S. Navy, 1194
INSEMINATION: See Impregnation, artificial
Preventing: See Contraception
INSTITUTE: See also Gade Institute; Kessler Institute; Societies and Other Organizations at end of letter S
for Research on Infertility, Israel, 1188
of Cytology, N. Y., 1184
on heart diseases, Iowa, 1026
INSTITUTIONS: See Hospitals; Schools; Schools, Medical
INSTRUCTION: See Education, Medical; Schools; University
INSTRUMENTS: See also Apparatus; Hearing Aids
electronic instrumentation, meeting on, 1027
for endotracheal anesthesia during oropharyngeal surgery, [Barton] *1017; (correction) 1460
INSTRUMENTS—Continued
Shedlovsky mobilometers to study viscosity of contraceptives, (Council report) [Gamble] *1019
Sterilization. See Sterilization, Bacterial
INSULIN
interdependent effects of stress and adrenal cortex on, [Clark] 979—ab
treatment for pain from potassium intoxication in Kimmelstiel-Wilson syndrome, [James & others] *545
INSULOMA (insulinoma)
spontaneous hypoglycemia from, [dePeyster] 1478—ab
INSURANCE
Accident: See Medicolegal Abstracts at end of letter M
claim forms simplified, (report) 953
Health: See Insurance, sickness; Medicolegal Abstracts at end of letter M
Hospitalization: See Hospitals, expense insurance
Indemnity: See Medicolegal Abstracts at end of letter M
life, Association of Life Insurance Medical Directors, annual meeting, 438
Life Insurance Medical Research Fund: See Foundations
malpractice, (Bureau report) 840; 954
National Insurance Scheme, new maternity benefits under, London, 1378
old-age and survivors, a physician and an economist look at, [Blasingame & Dickinson] *821; 959—E
Sickness: See also Hospitals, expense insurance
sickness, Committee on Prepayment Medical and Hospital Service, (report) 953
sickness, Committee on Relations with Lay Sponsored Voluntary Health Plans, 954
Sickness, National Health Service; Beveridge Plan: See National Health Service, England
sickness (voluntary), survey of physician attitudes toward, 1286—E
Workmen's Compensation: See Workmen's Compensation
INTER-AMERICAN: See Pan American
INTERCOURSE: Sexual: See Coitus
INTERMITTENT Claudication: See Claudication, intermittent
INTERN: See Interns and Internships
INTERNAL MEDICINE
American Board of: See American Board
graduate courses, Chile, 970
meeting on, Italy, 505
INTERNAL SECRETION, Glands of: See Endocrine Glands
INTERNATIONAL: See also list of Societies at end of letter S
Association for Public Welfare, Congress of, Paris, 748
Blood Transfusion Society, meeting, 41
Cancer Congress (sixth), July, 1954, 1292
College of Surgeons, Italian Section, 582
Commission on Radiation Protection, [Chamberlain] *188
Conference on Medical Education: See World Conference
Congress of History of Science (7th), Israel, 745; 970
Congress of Pediatrics, 41
Congress of Rheumatic Diseases, Switzerland, 1302
Congress of Surgery, centennial in São Paulo, 1027
Congress on Arterial Thrombosis, Paris, 876
Congress on Tuberculosis of 1908, [Placak] *798
Council of Pharmacologists, 497
Health Organization: See World Health Organization
Orthopedic Surgery, 6th meeting at Bern, 1559
symposium on cortisone, Italy, 1467
understanding, peace through, [Trimble] *1143
Union of Physiological Sciences, 571
vaccination certificate, new, 1194
INTERNS AND INTERNSHIPS: See also Preceptorships; Residents and Residencies
Advisory Committee on Internship, (Council report) *278; 943
approved internships, 1943-1953, *276
approved internships in U. S., annual report by A. M. A. Council, *275; 431—E; (list *282
award for interns, N. J., 436
deferment of interns *113
hospitals with highest autopsy rates, 1952-1953 (Council report) *279
intern year, required, students in, U. S., 1931-1953, *118
internship, medical schools requiring, *128
internships by medical school affiliation and hospital bed capacity, (Council report) *276; *277
internships by type of hospital control, number of, 1952-1953, *276
INTERNS AND INTERNSHIPS—Continued
internships by type of service, number of, 1952-1953, (Council report) *275; *276
internships, eligibility of 1954 graduates of new medical schools for, *132
internships, number of by census region and state, 1952-1953, (Council report) *277
National Intern Matching Plan, (Council report) *279; 943
new interns at Tripler Army Hospital, 872
number, September 26, 1953, page 275
one year internship, state boards requiring, *128
shortage of interns, 431—E
stipends, (Council report) *278
teaching interns on private services, [Armstrong] *83
INTERSEXUALITY: See Hermaphroditism
INTERVERTEBRAL DISK: See Spine
INTERVIEWING: See Counseling
INTESTINAL INFANTILISM: See Celiac Disease
INTESTINES: See also Cecum; Colon; Duodenum; Gastroenterology; Gastrointestinal Tract; Ileum; Peritoneum; Rectum
absorption, folic acid excretion test in malabsorption, [Girdwood] 765—ab
amebic granuloma in, Brazil, 745
antisepsis in surgery, [Poth] *1516
atresia, 17 cases, Mexico, 507
cancer, radiological examination, [Golden & Morales] *1431
Disease: See Typhoid
diverticulum (Meckel's), intrauterine perforation, [Rosza] 240—ab
diverticulum (perforating Meckel's), oxytetracycline in, [Schultz] 1489—ab
Fistula: See Fistula
Hernia: See Hernia
Inflammation: See also Ileitis
inflammation, fatal staphylococcus enteritis after penicillin and streptomycin therapy, [Fairlie & Kendall] *90
inflammation, regional enteritis, [Robinson] 597—ab; [Suermondt] 981—ab
inflammation, regional enteritis, roentgen study, [Golden & Morales] *1431
inflammation, regional enteritis; surgical treatment, [Palumbo] 516—ab
larva in, 178
obstruction, streptomycin and sodium sulfacetimide for, Brazil, 162
Parasites: See also Teniasis
parasites, differentiating and preserving protozoa in feces, [Bucki] 1125—ab
roentgen study, [Golden & Morales] *1431
roentgen study, limitation, [Swenson & Jeffrey] *1423
Surgery: See Gastroenterostomy
tuberculosis, x-ray study, [Golden & Morales] *1431
tumors, [Faber] 255—ab
tumors, x-ray study, [Golden & Morales] *1431
INTOXICATION: See Alcoholism; under names of substances as Potassium
INTRAVENOUS
Anesthesia: See Anesthesia
Injections: See Injections
INTRINSIC FACTOR
concentrate, Vitamin B12 with, N. N. R., (description) 565; (Organon) 565
INTUBATION: See Heart catheterization
INULIN
clearance test of renal function, [Goldring] *1245
INVALIDS: See Disease, chronic; Patients
INVESTIGATORS: See Research
IODINE
boiling test (Schlör): chemical pregnancy test, [Benthin] 1582—ab
prophylaxis and iodine deficiency, [Wespi] 176—ab
radioactive, early effects on thyroid function, [Myant] 1487—ab
radioactive, for thyroid cancer, [Rawson] 1203—ab; [Meckstroth] 1205—ab
radioactive, heart in I^{131} induced myxedema; [Kurland] 1052—ab
radioactive, treatment of hyperthyroidism, [Tubiana] 690—ab; [Costa] 1588—ab
radioactive, uptake in hypothyroidism, [Silverman] 1483—ab
treatment of blastomycosis in tuberculous patient, [Stillians & Klemptner] *560
IODIZED OIL (Lipiodol)
vaporization in bronchography, [Girard] 888—ab
IODOALPHIONIC Acid: See Acid
IODOPANOIC ACID: See Acid
IODOPYRACET (Diodrast; Diodone)
fatal complications from, used for angiography, [Utterback] 171—ab
percutaneous transhepatic cholangiography, [Nurick] 1583—ab
IONS
exchange resins, [Pannaccrilli] 1321—ab

IPRONIAZID (Marsilid)
treatment, drug resistant organisms during, [Coates] 593—ab
IRGAPYRIN: See Phenylbutazone
IRON
deficiency in dogs cause of anemia, [Van Wyk] 882—ab
treatment of hypochromic anemia, Italy, 1037
treatment: use of enteric coated ferrous sulfate and saccharated iron oxide, 1155—ab
IRRADIATION: See Radiation
ISLANDS of Langerhans: See Pancreas
ISONIAZID (Isonicotinic Acid Hydrazid; Nydrazid; Nladrin; Rimifon; Pyrizdin; Tyvid)
action of, singly and in combination, [Hobby] 240—ab
effect on emotions, 1524—E
N.N.R., (Hoffmann-LaRoche) 727
preparations, side-effects, [Pickroth] 771—ab
toxicity (neural) in tuberculous patients [Gammon] 676—ab
toxicity: psychic disorders, Paris, 48
treatment, clinical evaluation, [Cutler] 1575—ab
treatment, development of resistance to, [Berg] 1593—ab
treatment, drug resistant organisms during treatment, [Coates] 593—ab
treatment in pulmonary excision for tuberculosis, [Davidson] 247—ab
treatment of actinomycosis, [McVay & Sprunt] *95
treatment of childhood tuberculosis, [Boyd] 1585—ab
treatment of extrapulmonary tuberculosis, Chile, 1036
treatment of leprosy, [Latapi] 883—ab; [Argüello Pitt] 1139—ab
treatment of pulmonary tuberculosis, bacterial resistance in, [Medical Research Council] 1059—ab
treatment of pulmonary tuberculosis vs. 5 other agents, [Tempel] 589—ab
treatment of pulmonary tuberculosis, "recent lesion" factor in, [Bernard] 70—ab
treatment plus p-aminosalicylic acid and streptomycin in tuberculosis, Denmark, 1300; [Jensen] 1594—ab
treatment plus streptomycin in miliary tuberculosis and tuberculous meningitis, [Ritchie] 1223—ab
treatment plus streptomycin in renal tuberculosis, [Lattimer] 172—ab
treatment, "swing," in pulmonary tuberculosis, [Tanner] 1407—ab
ISONICOTINIC ACID HYDRAZIDES: See also Iproniazid; Isoniazid
treatment, drug resistant organisms during [Coates] 593—ab
ISOPROPYL ALCOHOL
as eye irritants, 455
examination of tissue sections, (replies) [Pickard] 1328
ISOTOPES: See also Radioactive Isotopes
catalog, both radioactive and stable isotopes 497
ISRAEL: See also Hebrew University
cancer of breast in women, [Kook] 765—ab
foreign letter from, 231; 745; 970
medical problems of immigration in, 971
physicians supply in, 745
ITALIAN
section of International College of Surgeons, 582
Society of Rheumatology, 746: 1178; 1372
ITCHING: See Eczema; Pruritus

J

J.A.M.A.: See American Medical Association Journal
JAFFE LECTURE: See Lectures
JAFFE-LICHTENSTEIN Dysplasia: See Dysplasia
JAPAN
abnormalities in 100 children, exposed in utero to detonation of atomic bomb, 218—E
JAUNDICE: See Medicolegal Abstract at end of letter M
Epidemic (Homologous Serum): See Liver Inflammation
JAWS: See also Teeth
tumors, multiple myelomas [Bruce] 247—ab
winking syndrome: diplopia after ankylosis of temporomandibular joint, 1231
JEJUNUM
roentgen examination in diseases of, [Golden & Morales] *1431
JEWS: See also Hebrew University: Israel
circumcision according to Jewish rite, 1497
dietary laws and salt-poor diet: sodium in processed meat, [Kisch] 1472—C
JOBS: See Industrial Health; Physicians, positions open
JOINT
Commission on Accreditation of Hospitals, (report) 944; 1448-E
Committee of A.M.A.: See American Medical Association
Committee on Hospital-Physician Relationships, report, President's page, 433
Committee on Medical Education in Time of National Emergency, *111
Conference on Mental Health, Oct. 24-25, 931; 1024
meeting on rural health, 733
JOINTS: See also Arthritis; under names of specific joints as Elbow; Hip; Knee; Shoulder
Charcot's (nontabetic): See Charcot's Joints
degenerative joint disease (osteoarthritis), hereditary aspects of Heberden's nodes, [Stecher] 166—ab
degenerative joint disease (osteoarthritis) toxic effects of phenylbutazone, [Nassim] 524—ab
Injuries, course on, Colorado, 734
Surgery: See Arthrodesis: Arthroplasty
Tuberculosis: See Arthritis, tuberculous
JONES (Everett O.) Scholarship Fund: See Scholarships
JOURNALS: See also Library; Newspapers
Annual Reports on Stress, reprints, [Selye & Horava] 1115—C
Archives published by A.M.A.: See American Medical Association journals (special)
Collier's magazine: statement by Dr. George F. Lull, 858; 927
Home Life, derogatory article in May, 1953 issue, 829
Hygeia (Today's Health): See American Medical Association, Today's Health
Index to: See American Medical Association, Quarterly Cumulative Index Medicus
Journal of the A.M.A.: See American Medical Association
Journal of Bone and Joint Surgery, 50th anniversary issue, 572
Journal of Forensic Medicine, new, 1187
Journal of Medical Society of New Jersey, 50th anniversary issue, 1103
Journal of Student American Medical Association, (report) 958
ophthalmic journalism, in America; history and present status (1862-1952) [Adler] *1358; 1365—E
Psychosomatic Medicine, anniversary issue dedicated to Dr. Cannon, 1187
shipment for Korea, [Rusk] 509—C
State Journal Advertising Bureau: See American Medical Association
State Medical Journal Conference, 434
Today's Health: See American Medical Association
translations center established by National Science Foundation, 659
translations pool of Special Library Association and John Crerar Library, 1371
trends in authorship, 1080—ab
JUDD Lecture: See Lectures
JUICES: See Orange Juice
JUMPING
Gilles de la Tourette's disease, (reply) [Yap] 528
JURISPRUDENCE, Medical: See Medical Jurisprudence

K

KALA-AZAR: See Leishmaniasis
KARTAGENER'S SYNDROME
in children, [Dickey] 243—ab
KATHEPSIN
proteolysis in gastric anacidity, [Bramstedt] 68—ab
KELLOGG Foundation: See Foundations
KENTUCKY
University of: See University
KERATITIS
nonsyphilitic interstitial, with deafness, [Oliner] 459—ab
KERATOSIS
hyperkeratosis affecting hands and feet, [Dencer] 1058—ab
of larynx as premalignant lesion, [Putney] 978—ab
KERNICTERUS
hemolytic disease of newborn due to ABO incompatibility, [Dunn] 448—ab
KESSLER INSTITUTE, (workshop) 436; (clinic for amputee children) 736
KETOSIS
Diabetic: See Diabetes Mellitus, acidosis
KHELLIN (Visammin)
evaluation of coronary vasodilators, [Russek & others] *207
KIDNEYS: See also Ureters; Urinary System
artificial, peritoneal dialysis in toxic conditions, [Henninger] 170—ab
KIDNEYS—Continued
biopsy (needle) [Payet] 1131—ab
calculi, 1231
calculi, hyaluronidase in, [Tinaccl] 1592—ab
cysts, polycystic kidney, associated with intracranial aneurysms, [Bigelow] 58—ab
cysts, polycystic renal disease, 992
disease, intermediate nephron nephrosis in rattlesnake poisoning, Brazil, 1376
disease, lipoid nephrosis, distinguishing from glomerulonephritis, [Keith & Odel] *1240
disease, nephropathia epidemica, Norway, 1470
disease, nephrotic state, treatment, especially with ACTH, cortisone and hydrocortisone, Luetscher & others] *1236
disease, nephrotic syndrome with paramethadione therapy, also trimethadione [Wren & Nutt] *918
disease, pain from potassium intoxication in Kimmelstiel-Wilson syndrome, [James & others] *545
disease, renal osteodystrophy, [Dragsted] 690—ab
disease, tubular nephrosis in shock, [Moon] 589—ab
disease, with salt losing syndrome, [Murphy] 449—ab
endangiitis obliterans of, relation to hypertension, [Fellmann] 768—ab
factors in hypertension, [Wilson] 1587—ab
function in hexamethonium-induced hypotension, [Schweizer] 1213—ab
function tests (current), clinical application; composite function test, [Goldring] *1245; (correction) 1460
Glomeruli: See Nephritis, glomerular
Inflammation: See Nephritis
insufficiency (acute and chronic), advances in treatment [Corcoran] *1233
insufficiency, ammonia, urea, and uric acid in, [Rolliger] 1582—ab
insufficiency, pattern of functional recovery in acute renal failure, [Kaplan] 448—ab
insufficiency, treatment of hyperkalemia in acute renal failure, [Knowles] 1119—ab
lesions, gross urinary hemorrhage: symptom, not a disease, [Lee & Davis] *782
necrosis in pregnancy, [McKay] 1206—ab
perirenal oxygen insufflation: Carelli's technique, [Ritter] 244—ab
physiology (comparative), [Smith] *1512
symposium on, N. C., 570
tuberculosis, streptomycin, PAS, and isoniazid treatment, [Lattimer] 172—ab
tumors, adenoma, [Childs] 1403—ab
tumors, Wilms', in infant, 1597
tumors, Wilms' in man 51, [van Gulik] 1224—ab
"KILLED in Action": See Korean War, Heroes
KIMBLE Methodology Research Award: See Prizes
KIMMELSTIEL-WILSON DISEASE
pain from potassium intoxication in; insulin and glucose control, [James & others] *545
KING EDWARD'S Hospital Fund: See Hospitals
KINSEY REPORT
anatomy of pubococcygeus muscle and sexual physiology of vagina, [Kegel] 1303—C
sexual life of young Danish women, 1300
KNEE
compression arthrodesis using double wire and tightening lever, [Greifensteiner] 603—ab
pain and swelling in both knees, 693
repair of ruptured patellar tendon with airplane control cable, [Chandler] *1093
KNOWLAND PROPOSAL
vs. Bricker Amendment to U. S. Constitution, 566—E
KOCH, WILLIAM FREDERICK
cancer quack, J. S. Schirmer associated with, 647—E; 669—B1
KOCH'S Bacillus: See Tubercle Bacillus
KOLLIDON: See Polyvinylpyrrolidone
KOREA
A.M.A. resolution on expressing appreciation to physicians of, (report) 927
emergency library for Seoul National University school of Public Health, 1184
46th Surgical Hospital in, 1466
shipment of periodicals and books to [Rusk] 509—C
KOREAN WAR, 1950—
G. I. Bill for those serving in: See G. I. Bill of Rights
KOREAN WAR, HEROES
Engelbreit (J. J.), killed in action, (photo) 579
Graveline (E. L., Jr.) died in communist prison camp, 1297
KRESGE Foundation: See Foundations
KUNTSCHER'S Method: See Fractures, treatment

KWASHIORKOR
(Council article) [Williams] *1280
KWELL: See Benzene Hexchloride, gamma
KYPHOSIS: See Spine

L

LABOR: See also Abortion; Cesarean Section; Hospitals, maternity; Infants, Newborn; Maternity; Obstetrics; Pregnancy
Anesthesia in: See Anesthesia
calcium for uterine inertia, 1141
Complications: See also Eclampsia
complications: cerebral palsy and pregnancy, 1497
Death during or after: See Maternity mortality
deliveries in hospital or at home, Sweden, 49
forceps, place in modern obstetrics, 1450—E
Intrauterine anoxia as cause of fetal death during [Taylor] 522—ab
onset of, vs. hour of birth, London, 583
Postpartum Complications: See Puerperium
Premature: See also Infants, premature
premature, causes of [Rolfsen] 1130—ab
problems of delivery discussed at St. Louis Clinical Meeting, 494
prolonged, clinical evaluation, [McCain & others] *695
remote effects on child, [Benaron] 1206—ab
twins in double uterus; one twin born 56 days after other, [Williams] 599—ab
LABOR (industria.): See industrial Accidents; Industrial Diseases; Industrial Health; etc.
LABOR UNIONS: See Industrial Trade Unions
LABORATORIES
A.M.A. Laboratories, (report) 937
guides for bulbar poliomyelitis, Memorial Hospital, Sheridan County, Wyo., [Varga] 50—C
Nelson, opened in Vienna, 867
office, course on, N. Y., 1184
public health (new), S. C., 1458
research, at Los Alamos, Calif., 1454
studies in geriatrics, [Kountz] *779
Technicians: See Technologists
tests, false positive, 561—ab
tests vs. stethoscopes, unjustified and unnecessary tests, 997—ab
use in coroner's system, [Turkel] *1088
LABORIT Method: See Cold, therapeutic use
LABYRINTH: See Ear, internal
LACRIMAL SAC
most effective treatment for resistant, purulent dacryocystitis, 991
LACRIMATION
congenital absence of tear secretion [Sjögren] 452—ab
epiphora: what causes eyes to water? 608
LACTATION
influence on nutritional processes, [Spies] *183
LACTOBACILLUS casei factor (synthetic): See Acid, folic
LACTOFLAVIN: See Riboflavin
LADEY, FRANK H.
memorial to, (report) 946
LAME: See Crippled
LAMENESS: See Claudication
LAMINAGRAPHY
roentgen localization of bronchopulmonary segments, [Adler] 1047—ab
LANATOSIDE C
intravenous digitalization, 1496
LAND: See Soil
LANGERHANS, Islands of: See Pancreas
LANGUAGE: See Terminology
LAPAROTOMY: See Abdomen surgery
LARSON, LEONARD W., receives pathologists' award, 1024
LARVA
intestinal tract, 178
LARVA MIGRANS
treatment, hetrazan, [Kelley] 1210—ab
visceral, cause of, eosinophilia in childhood, [Dent] 683—ab
LARYNGOLOGY: See Otorhinolaryngology
LARYNGOTRACHEOBRONCHITIS
treatment, tracheotomy, [Davis & others] *1156
LARYNX: See also Otolaryngology; Otorhinolaryngology
cancer, esophagolaryngectomy (Wookey operation) in elderly, [Lam & Gordon] *552
keratosis as premalignant lesion, [Putney] 978—ab
LASDON Foundation: See Foundations
LATAH REACTION
Gilles de la Tourette's disease, (reply) [Yap] 528
LATIN AMERICAN: See Pan American
LAUNDRIES
recontamination of washed bedding in, [Church] 756—ab
LAW
in relation to Physician: See Medical Jurisprudence
LAWS AND LEGISLATION: See also Medical Practice Act
A.M.A. Bureau of Legal Medicine and Legislation; See American Medical Association
LAWS AND LEGISLATION—Continued
artificial insemination, Norway, 876
Doctor-Draft Law: See Medical Preparedness
federal, (A.M.A. Committee on Legislation report) 834; (survey by A.M.A. Washington Office) 843; 1182
federal food and drug laws, [Seevers] *1329
GI Bill: See GI Bill
legal abortion statistics, Sweden, 1569
state, Bureau report, 839
Violation of: See Medical Jurisprudence; Medicolegal Abstracts at end of letter M
LAWSUITS: See Medical Jurisprudence
LAXATIVES: See Cathartics
LEAD
absorption increased from pica, [van Wisselingh] 69—ab
poisoning, diagnosis in factory workers, 608
poisoning, France, 1197
poisoning, porphyria from, [Shields] 1488—ab
LECTURES: See also under Book Reviews at end of letter B
Albee, 496
Alvarenga, 866
Anders, 1186
Beling (C. C.) Memorial, 962
Billings, [White] *75
Cook (W. Albert), 1458
DeLee, 734
Dickinson Memorial, 1184
Doheny Eye Foundation, 864
Dunham, 435
Fahr, 154
Ford (Edsel B.), 1289
Friedenwald (Julius) Memorial, 864
Harvard, 734
Harvey, 569; (3rd) 1026; (4th) 1370
Hauswirth (Louis), 1185
Jaffe, 864
Judd-Plummer Memorial, 650
Long (Leroy H.), [Hall] *615
Martland, 1289
Mellon, 1027
Molina (Ricardo D.), 1460
Museum of Science and Industry, Ill., 495
New England Center, 735
Pemberton Memorial, 737
Phi Delta Epsilon, 222; 962; 1557
Philips, 1104; 1186
Proctor (Francis I.) 1183
Ranson, 735
Reiss Memorial, 1104
Remer (Harry G.) first, 1289
Rigler, 736
Salmon, 1026
Schick (Bela), 865
Shattuck, on penicillin by Fleming, 94—ab
Strauss, 497
Terry, 1184
Williams Memorial, 865
LEFT HANDEDNESS
training children who are left-handed, (reply) [Blau] 894
LEG: See Legs
LEGAL MEDICINE: See Laws and Legislation; Medical Jurisprudence; Medicolegal Abstracts at end of letter M
A.M.A. Bureau of: See American Medical Association
LEGAL RESPONSIBILITY: See Malpractice
LEGISLATION: See Laws and Legislation
LEGS: See also Ankle; Femur; Foot; Knee; Hip; Hosiery
Amputation: See Amputation
arteritis, heparin for, [Remy] 1130—ab
calf circumference: diagnostic aid in thrombophlebitis, [Dumon & McFarland] *622
Cramps of: See Cramps
Fractures: See under names of specific bones as Femur
Milk Leg: See Phlegmasia cerulea dolens
pain from retroperitoneal tumor, [Anderson] 1052—ab
LEIODYSTONIC SYNDROME
in indigenous disease, [Pock-Steen] 1593—ab
LEISHMANIASIS
control by spraying houses with DDT, Brazil, 1299
mucocutaneous, Brazil, 47
LEISURE CORNER
cooking for pleasure, *975
flowering hobby, *55
model railroading: father-and-son hobby, *1310
"Sunday" painter, *508
LENS CRYSTALLINE
Opacity: See Cataract
Retrolental Fibroplasia: See Retrolental Fibroplasia
LENTICULAR NUCLEUS
hepatolenticular degeneration, Wilson's disease, [Sullivan] 513—ab
LEPROSY
American Leprosy Missions, Inc., appoint medical adviser, 156
etiological factor in Webster-Christian syndrome, [Birrell] 1223—ab
Hansenosis as term for, [Feldman] 1041—C
in Mexico, 1568
Johansen (F. A.) honored by American Legion Auxiliary, Miss., 1455
leprologist wanted, 1105
treatment, isoniazid, [Latapi] 883—ab; [Argüello Pitt] 1130—ab
LEPROSY—Continued
tuberculosis in; treatment, [Lima] 1190—ab
LEPTOSPIROSIS
epidemiology of canicola fever, [McIntyre] 1586—ab
in acute pancreatitis, Brazil, 1195
LETTERER-SIWE DISEASE
multiple bone lesions in, [Fisher] 62—ab
LEUKEMIA
complicating pregnancy, irradiation for, [Kaplan] 64—ab
extracts (Ak), filtrable agent causing mouse salivary gland carcinoma, 150—E
in children; cancer in their families, [Amiotti] 1324—ab
medicosurgical meeting discusses, Chile, 1565
myeloid, incidence; treatment, [Ledlie] 523—ab
remissions in after infections, [Bierman] 60—ab
treatment, aminopterin, ACTH and cortisone for acute type in children, [Kass] 1224—ab
treatment, corticotropin, [Spies] *189
treatment, splenic X-irradiation, bone marrow changes after, [Gunz] 1049—ab
deVilliers Foundation award, 1290
with fever, 1415
LEUKOCYTES
Count: See also Agranulocytosis; Leukemia; Mononucleosis, Infectious
count in cyclic neutropenia (at 21-day intervals), [Coventry] *28
count, leukopenia after using fumagillin for amebiasis, [Malewitz] *1446
count, low in radiation workers, [Turner] 1216—ab
Eosinophilic: See Eosinophils
LEUKO-ERYTHROBLASTOSIS: See Erythroblastosis
LEUKOPENIA: See Leukocytes count
LEUKOTOMY, Orbital: See Brain surgery
LEVARTERENOL BITARTRATE (Levophed)
treatment of acute hypotensive states, [Barlow] 1132—ab
LEVINSON Foundation: See Foundations
LEVOPHED: See Levarterenol
LEVUGEN: See Fructose
LEVULOSE: See Fructose
LIABILITY: See Malpractice
Insurance: See Insurance, malpractice
LIBRARY: See also Books; Journals; Newspapers
Denver County Medical Society, Colo., 36
emergency, for Korean School, Mass., 1184
John Crerar Library and Special Libraries Ass'n. translations pool, 1371
medical, at Hebrew University-Hadassah Medical School, Israel, 231
Texas Memorial, (photo) 152
LICENSURE: See also State Board
A.M.A. Annual Congress on, (report) 945
diploma mills: investigation of Jacob S. Schirmer by Arkansas attorney general, 647—E; 665—BI
uniform, Committee to Study, (Bureau report) 838
LICHTENSTEIN-Jaffe Dysplasia: See Dysplasia
LICORICE: See Glycyrrhiza
LIDS: See Eyelids
LIFE: See also Death
Duration: See also Old Age; Physicians, veteran
duration in essential hypertension, [Palmer & Muench] *1
duration in wage earners, 652
expectancy in diabetics, 1187
expectancy, widowhood, 1501—ab
how to live, 1085—ab
Insurance: See Insurance
Insurance Medical Research Fund: See Foundations
Stress: See Stress
LIGATURE: See Sutures
LIGHT: See Sunlight
LIMP: See Claudication
LINEAR ACCELERATOR
new developments in radiotherapy, London, 1301
LINEN
surgical, bacterial sterility, [Propst] 1489—ab
LINGO, W. B., diploma mill operator, 666—BI
LIPIDS
in urinary sediment, Sudan 3 stain for, [Magath] 1041—C
LIPIODOL: See Iodized Oil
LIPOID
Nephrosis: See Kidneys, disease
LIPOMA
syndrome in sacral region; pathogenesis of backache, [Schmidt-Voigt] 598—ab
LIQUOR, Alcoholic: See Alcohol; Alcoholism
LITERATURE: See also Books; Journals; Newspapers; Terminology; Writers
Association of Spanish Physicians organized contest, 748
scientific, weaknesses; presuppose physician's knowledge [Torcivia] 1380—C
LITHIASIS: See Calculi (cross reference)
LITTLE'S Disease: See Paralysis, cerebral
LIVER: See also Bile Ducts; Biliary Tract
biopsy, courses on, 867
biopsy, (needle) in thyrotoxicosis, [Movitt] 237—ab

V 15
1953

LIVER—Continued
biopsy (punch) in children, [Sansone] 1129—ab
biopsy, value and limitation, [Fazlo] 766—ab
calculi, hepatolithiasis, [Hicken] 977—ab
cancer (primary), [Liu] 886—ab
cirrhosis, gastrointestinal hemorrhage in, Palmer] 519—ab
cirrhosis: hematological, immunological, and hemostatic changes, Chile, 1036
cirrhosis, posthepatic, [Baggenstoss] 451—ab
cirrhosis, surgery for bleeding esophageal varices after, [Linton] 168—ab
cirrhosis with gastroduodenal ulcer, [Antonini] 1218—ab
disease, noninfectious, Italy, 233
disease symptoms of acute anterior poliomyelitis, [Kalk] 1218—ab
disease with ulcerative colitis, [Bargen] 881—ab
estrogen metabolism dependent on, [Mayer] 1584—ab
Extract: See Liver preparations
function in hexamethonium-induced hypotension, [Schweizer] 1213—ab
function in paraplegia, [O'Connell & Gardner] *710
function test, sulfobromophthalein, [Goodman & Kingsley] *162
Hepatolenticular Degeneration: See Lenticular Nucleus
Inflammation: See Liver Inflammation *following*
Inflammation (Chronic): See Liver cirrhosis
necrosis (acute) after chloramphenicol, [Salm] 1128—ab
nodules encountered at laparotomy, [Mixter] 1049—ab
preparations, liver extract and vitamin B_{12} treatment in children, [Masi] 1129—ab
preparations, liver extract, folic acid, and vitamin B_{12} in pernicious anemia, [Canelas] 1215—ab
surgery, massive resection, 614—ab
tumors (primary benign) in children, [Christopherson] 1180—ab
LIVER INFLAMMATION (infectious hepatitis; epidemic jaundice): See also "Hepatitis" under Medicolegal Abstracts at end of letter M
acute hepatitis in children, [Niemeyer] 601—ab; (Chile) 1112
eosinophilia in, Mexico, 507
in childhood, [Murphy] 245—ab
in children, histological diagnosis, [Perry] 1128—ab
posthepatic cirrhosis, [Baggenstoss] 451—ab
safety of immune serum globulin, [Murray] 1055—ab
transmission by blood and plasma transfusions, [Hässig] 254—ab
transmission, thrombin source of outbreak, Maine General Hospital, [Porter & others] *17
treatment, corticotropin and cortisone in severe and fulminant form, [Evans] 448—ab
virus, experiments with [Wildführ] 1408—ab
LIVESTOCK: See Animals
LIVING: See Life
LOANS
for Medical Students: See Students, Medical
LOBECTOMY: See Lungs, surgery
LOBOTOMY: See Brain surgery
LOCKJAW: See Tetanus
LOCOMOTOR ATAXIA: See Tabes Dorsalis
LOGAN, W. P. D., analyzes records of general practitioners, London, 1469
LONG (Leroy) Lecture: See Lectures
LONGEVITY: See Life duration; Old Age; Physicians, veteran
LOS ANGELES
County Medical Association, first aid instructions for household emergencies, 647—E
Welfare Council of Metropolitan Los Angeles, provisions for servicemen's dependents, (Council article) [Carter & others] *51
LOW BLOOD PRESSURE: See Blood Pressure, low
LUER-HUB NEEDLES
simple coupling device for polyethylene catheter, [Alman & Whoriskey] *562
LULL, GEORGE F.
statement by, on article in Collier's magazine, 858: 927
LUNGS: See also Bronchus; Pleura; Respiratory System
air cysts, [Harden] 62—ab
air spaces (abnormal) in: cysts, bullae, pneumatoceles, [Mayer & Rappaport] *700
anomalies, intralobar sequestration, [Boyd] 755—ab
blood circulation, effect of oxygen on, in mitral valve stenosis, [McGregor] 879—ab
blood circulation time (lung-duodenum) in portal hypertension, Brazil, 1376
blood pressure, patent ductus arteriosus with pulmonary hypertension, [Hultgren] 681—ab
cancer, blood supply of, [Cudkowicz] 985—ab
cancer, (bronchogenic), cell types in, [Moersch] 243—ab
LUNGS—Continued
cancer (bronchogenic), operative treatment, Denmark, 581
cancer (bronchopulmonary), [Gagnon] 986—ab
cancer, frequency in private practice, [Sayago] 602—ab
cancer, improved results in treating, [Hansen] 690—ab
cancer, management, [Boyce] 1312—ab
cancer, medicosurgical meeting discusses, Chile, 1565
cancer, metastases from breast, [Stoll] 1584—ab
cancer, Warning Shadow (film review) 1573
cavitation within bland infarcts, [Soucheray] 755—ab
"coin" lesions, [Trimble] 243—ab; [Storey] 522—ab
Collapse: See also Pneumothorax; Pneumothorax, Artificial
collapse, atelectasis, hyaline membrane and cysts in newborn, [Cooper & others] *1077
cryptococcosis, [Stiefel] 1407—ab
Disease: See also Pneumonoconiosis
disease and airplane travel, 1435—ab
disease (chronic), cardiac catheterization in, [Divry] 1126—ab
Embolism of Pulmonary Artery: See Embolism, pulmonary
farmer's, [Studdert] 524—ab
Fibrosis: See Pneumonoconiosis
foreign bodies (dental) in, 35—E
Hemorrhage: See Hemoptysis
Infection: See also Bronchopneumonia; Influenza; Pneumonia; Tuberculosis of Lung
mucocele from congenital obstruction of segmental bronchus, [Ramsay] 590—ab
paragonimiasis, [Roque] 449—ab
pathology, rheumatic cardiopathy and cor pulmonale, [Taquini] 984—ab
roentgen aspects of tuberculous lesions treated with streptomycin, [Dubarry] 1060—ab
roentgen localization of segments with laminagraphy, [Adler] 1047—ab
sarcoidosis (primary), [Löfgren] 981—ab
Silicosis: See Pneumonoconiosis
surgery, emergency resection for massive hemoptysis, [Ross] 1578—ab
surgery, improvements in indications for pneumonectysis, Brazil, 969
surgery, isoniazid in excision for tuberculosis, [Davidson] 247—ab
surgery, lobectomy in lobar obstructive emphysema in infancy, [Sloan] 758—ab
surgery, prognosis of contralateral lung after resection, [Geake] 985—ab
surgery, resection for local necrotic lesions in tuberculous, [Forsee] 1576—ab
surgery resection in first year of life, [Crossett] 1580—ab
surgical consideration in focalized pulmonary histoplasmosis, [Forsee] 980—ab
tension disorders in infants and children, [Campbell] 1125—ab
Tuberculosis: See Tuberculosis of Lung
tumors, adenoma, [Hutchison] 1583—ab
tumors, plasmacytoma with hypertrophic osteopathia, [Plenk] 770—ab
LUPUS ERYTHEMATOSUS
actinic dermatitis, 1232
acute, cortisone and corticotropin in, Italy, 1467
discoid chronic, fatal aplastic anemia after using quinacrine, [Parmer & Sawinsky] *1172
discoid chronic, quinacrine and chloroquine for, [Farber] 1580—ab
discoid chronic, quinacrine for, [Cole & others] *1515
discoid, large doses of vitamin B_{12} in, [Marcus] 1050—ab
discoid, quinacrine for, [Miller] 1055—ab
disseminated, involving spinal cord causing paralysis of lower extremities, [Piper] *215
treatment, cortisone and corticotropin, [Cohen] 1221—ab
LYMPHATIC SYSTEM: See also Mononucleosis, Infectious
caseation necrosis of nodes in human brucellosis, [Crow] 241—ab
excision of skin neoplasms, 776; (reply) [Fulmer] 1498
lymphadenitis (regional) and "cat scratch disease," [Tonge] 1323—ab
lymphangitis, cat scratch disease and Parinaud's conjunctivitis, [van Veelen] 453—ab
perforation (endobronchial) of nodes, [Dufourt] 1490—ab
thoracic lymphatics, anatomic and radiological studies, Mexico, 1113
tuberculosis of superficial nodes, [Gale] 1585—ab
LYMPHEDEMA: See Elephantiasis
LYMPHOBLASTOMA
mediastinal, surgical treatment, [Thorek] 214—ab
LYMPHOCYTES
in arterial hypertension, [Taquini] 70—ab
LYMPHOGRANULOMA
Benign: See Sarcoidosis
Malignant: See Hodgkin's Disease
LYMPHOGRANULOMA, VENEREAL
treatment, aureomycin, Turkey, 877
LYMPHOGRANULOMATOSIS: See Hodgkin's Disease
LYMPHOMA
malignant, roentgen therapy, [Hynes] 1047—ab
tuberculous, of neck, [Stiefel] 1061—ab
LYMPHOMATOSIS
inguinal (subacute suppurative), aureomycin for, Turkey, 877
LYMPHOPATHIA Venerea: See Lymphogranuloma, Venereal
LYMPHOSARCOMA
complicating pregnancy, irradiation for, [Kaplan] 64—ab

M

MACARONI
Helbz Junior Macaroni and Cheese, 1521
McCORMICK, EDWARD J.
A.M.A. President, (monthly message), (Sept.) 433; (Oct.) 875; (Nov.) 1178; (Dec.) 1525
A.M.A. President's address at St. Louis Clinical Meeting, *1529
statement before U. S. House Committee, (on retirement funds for self-employed persons) 151: (on medical research and progress) 730
MACHINE: See Apparatus
MACULA LUTEA
senile degeneration cause of blindness, England, 1469
MAGAZINES: See Journals
MAGIC
medicine, and religion, London, 971
MAGNAMYCIN: See Carbomycin
MAIL: See Postage Stamps
MAINE
Medical Association, Committee on Civil Defense, plans for special weapons, 859
MAL del Pinto: See Pinta
MALABSORPTION SYNDROME
toxic acid excretion test in, [Girdwood] 765—ab
MALAMUD-SANDS WORCHESTER RATING SCALE
in aged, effect of drug therapy, [Levy] *1260
MALARIA
insect control and, by U. S. Navy, 1194
therapeutic, in neurosyphilis, follow-up, [Thomas] *719
treatment, amino acids, Brazil, 1195
treatment, single intramuscular injection of chloroquine, [Jelliffe] 453—ab
MALE: See Semen; Spermatozoa
Characteristics: See Virilism
Hormone: See Androgens
Impotence: See Impotence
MALFORMATIONS: See Abnormalities
MALIGNANCIES: See Cancer; Sarcoma; Tumors, malignant
MALINGERING
hemorrhage from self-medication with bishydroxycoumarin, [Cosgriff] *547
MALLET Finger: See Fingers
MALPRACTICE: See also Medicolegal Abstracts at end of Letter M
Grievance Committee: See Societies, Medical
Insurance: See Insurance, malpractice
medical, Subcommittee on, (Committee report) 850
MALTA FEVER: See Brucellosis
MAMMARY: See Breast
MANN-KOES method for staining eosinophils, 1067
MANNING Scholarship: See Scholarships
MANSLAUGHTER: See Murder
MARAGLIANO'S VACCINE: See Tuberculosis, Immunization
MARIE-Strümpell Arthritis: See Spine arthritis
MARKING Ink: See Ink
MARKLE Foundation: See Foundations
MARKS: See Grades
MARRIAGE: See also Coitus; Contraception; Impregnation; Maternity; Paternity; Pregnancy
influence on breast cancer, Norway, 663
skin pigmentation in intermarriage, (reply) [Whipple] 880
MARROW: See Bone Marrow
MARSILID: See Iproniazid
MARTLAND Lecture: See Lectures
MASCULINIZATION: See Virilism
MASTECTOMY: See Breast surgery
MASTER Two-Step Test: See Heart function
MASTOID
region, congenital fibrosarcoma in, [Hartz] 1127—ab
MASTURBATION
in women, relation to orgasm; Kinsey report, [Kegel] 1303—C
MATCHING PLAN: See Interns and Internships
MATCHLESS Brand Dietetic Pack Products
apple sauce, beans, beets, carrots, 217
sweet corn, whole kernel corn, sweet peas, 645
MATERNITY: See also Labor; Lactation; Pregnancy
benefits (new) under National Insurance Scheme, London, 1378
care, (Council report) 950
care provisions for servicemen's dependents, (Council article) [Carter & others] *51
Hospitals; Service; Wards: See Hospitals
mortality, study of, Mass., 1455

MATRIMONY: See Marriage
MEASLES
German: See Rubella
in Greenland, 581
treatment, convalescent serum, 1496
treatment, gamma globulin, [Lamarca] 767—ab
MEAT: See also Trichinosis
processed by Jewish law, sodium content, [Kisch] 1472—C
MECKEL'S Diverticulum: See Intestines, diverticulum
MEDALS: See Prizes
MEDIASTINUM
roentgen study by injecting air, Barlety technic, Paris, 584
tumors, lymphoblastoma, surgery for, [Thorek] 244—ab
MEDIATION Committee: See Societies, Medical, county, grievance committee
MEDICAL ASSOCIATION: See American Medical Association; Association; Societies, Medical
MEDICAL AUXILIARIES: See also Woman's Auxiliary
system of, recommended by Cope Committee, London, 971
MEDICAL AWARDS: See Prizes
MEDICAL BENEFITS FUND OF AUSTRALIA
answer to socialized medicine schemes, 231
MEDICAL BOOKS: See Books; Library; Book Reviews at end of letter B
MEDICAL CARE: See Medical Service
MEDICAL CENTER: See also Health center
Columbia-Presbyterian, N. Y., 569
staff program, Texas, 968
MEDICAL CLINIC: See Clinics
MEDICAL CODE: See Ethics, Medical
MEDICAL COLLEGE: See Schools, Medical; University
MEDICAL CONFERENCE: See Conference
MEDICAL CONGRESS: See Congress
MEDICAL CORPS: See Armed Forces; Army, U. S.; Navy, U. S.; Veterans Administration
MEDICAL DAYS
cycles of, meeting at San Luis Potosí, Mexico, 234
in France, 1460
in Montecatini, Italy, 232
MEDICAL DEFENCE UNION, London, 1470
MEDICAL DIATHERMY: See Diathermy
MEDICAL ECONOMICS: See Economics, Medical
MEDICAL EDUCATION: See Education, Medical
MEDICAL ETHICS: See Ethics, Medical
MEDICAL EXAMINATION: See Physical Examination
MEDICAL EXAMINERS: See also Coroners
law, model, (Bureau report) 839
system compared with coroner system, [Turkel] *1086; 1100—E
MEDICAL EXPENSE INSURANCE: See Hospitals, expense insurance
MEDICAL FEES: See Fees
MEDICAL FELLOWSHIPS: See Fellowships
MEDICAL FILMS: See Moving Pictures
MEDICAL FOUNDATIONS: See Foundations
MEDICAL GRADUATES: See Graduates
MEDICAL HISTORY: See Medicine, history
MEDICAL ILLUSTRATORS; Illustration: See Art; Photography
MEDICAL INDEX: See American Medical Association, *Quarterly Cumulative Index Medicus*
MEDICAL INSTITUTE: See Institute
MEDICAL JOURNALS: See Journals
MEDICAL JURISPRUDENCE: See also Laws and Legislation; Malpractice; Medicolegal
Coughlin case; fight to deduct cost of graduate study from income tax, (Bureau report) 837
definition of a physician, Belgium, 666
fellowship in medicolegal pathology, Md., 1455
Journal of Forensic Medicine, established 1187
Medical Defense Union, London, 1470
medicolegal aspects of coroner system, [Turkel] *1086; 1100—E
medicolegal experiences under Ohio coroner's system, [Landé & Boone] *179
medicolegal institute, Mich., 1289
medicolegal lectures, N. Y., 496
opinion on practice of radiology in and by hospitals, (Bureau report) 838
Subcommittee on Courses in, (Committee report) 836
Supreme Court (Nebraska) held that unborn child is part of its mother until birth, (Bureau report) 839
MEDICAL LECTURES: See Lectures
MEDICAL LEGISLATION: See Laws and Legislation
MEDICAL LIBRARY: See Library
MEDICAL LICENSING Board: See State Board
MEDICAL LICENSURE: See Licensure
MEDICAL MAGAZINES: See Journals
MEDICAL MEETINGS: See American Medical Association; Societies, Medical; list of Societies at end of letter S
MEDICAL MOTION PICTURES: See Moving Pictures
MEDICAL MUSEUM: See Health museum
MEDICAL OFFICERS: See Armed Forces; Army, U. S.; Health, USPHS; Medical Preparedness; Navy, U. S.
MEDICAL PARTNERSHIPS: See Partnerships
MEDICAL PERIODICALS: See Journals
MEDICAL PHOTOGRAPHY: See Photography
MEDICAL PICTURES: See Art; Moving Pictures, Medical; Photography; Television
MEDICAL PRACTICE: See Medicine, practice; Physicians
MEDICAL PRACTICE ACT: See also Medicolegal Abstracts at end of letter M
modern, Committee to Study Essentials of, (Bureau report) 838
MEDICAL PREPAREDNESS: See also Civilian Defense
doctor-draft law, Armed Forces faced with surplus of medical officers, 34—E
doctor-draft law, military requirements for physicians, 1022—E
doctor draft law of 1953, *113; 840
doctor draft regulations, analyses, (Council report) 1201
medical education and national defense, Joint Committee on Medical Education in Time of National Emergency, *111
physicians for Armed Forces, 432—E; 1022—E
recruitment of medical personnel, [Kerr] *457
selective service system: college student certificate; eligibility for deferment, *112
MEDICAL PRIZES: See Prizes
MEDICAL PROFESSION: See Medicine, profession of; Physicians; Specialists; Surgeons
MEDICAL PUBLIC RELATIONS: See Public Relations
MEDICAL RESEARCH: See Research
MEDICAL RESEARCH COUNCIL
annual report, London, 661
bacterial resistance in tuberculosis treated with isoniazid, 1059—ab
investigation on common cold virus, London, 1058
radiotherapy with cyclotron and linear accelerator, 1301
saccharin only artificial sweetening substance allowed, London, 1039; 1378
MEDICAL RESERVES: See Navy, U. S.
MEDICAL RESPONSIBILITY: See Malpractice
MEDICAL SCHOOLS: See Schools, Medical
MEDICAL SCIENCE: See Medicine; Research
Basic: See Basic Sciences
MEDICAL SERVICE: See also Health center; Hospitals; Insurance, sickness; Medical Center; Medicolegal Abstracts at end of letter M
A.M.A. Council on Medical Service: See American Medical Association
A.M.A. Council on National Emergency Medical Service: See American Medical Association
Center: See Medical Center
Emergency Calls: See Emergency
federal, A.M.A. Committee on, (report) 952
Fees for: See Fees
for Armed Forces: See Army, U. S., Armed Forces; Medical Preparedness
for Dependents of Servicemen: See Servicemen
for Indigent: See Medically Indigent
for Veterans: See Hospitals, veterans; Veterans
Hoover Medical Task Force on, members of, 1298
Industrial: See Industrial Health
interservice utilization of expert military clinical consultants, [Hammond] 973—C
price indexes, old and new base periods for, Bulletin 95, (Bureau report) 844
Rural: See Rural Communities
Supply of Physicians for: See Physicians, supply
MEDICAL SERVICE PLANS: See Hospitals, expense insurance
MEDICAL SOCIETY: See Societies, Medical; list of societies at end of letter S; Medicolegal Abstracts at end of letter M
MEDICAL STATISTICS: See Statistics; Vital Statistics
MEDICAL STUDENTS: See Students, Medical
MEDICAL SUPPLIES: See Apparatus; Drugs; Instruments
MEDICAL TECHNOLOGISTS: See Technologists
MEDICAL TERMINOLOGY: See Terminology
MEDICAL WOMEN: See Physicians, women; Students, Medical, women
MEDICAL WRITING: See Literature; Writers
MEDICALLY HANDICAPPED: See Blindness; Crippled; Disability; Handicapped
MEDICALLY INDIGENT
A.M.A. Committee on Indigent Care, (report) 949
teaching material survey on indigent care, (report) 950
MEDICATION: See Drugs; Self-Medication
MEDICINE: See also Education, Medical; Medical Service; Physicians; Surgeons; Surgery
Advances in: See Medicine, progress
Aviation: See Aviation
Congress of: See Congress
MEDICINE—Continued
Faculty of: See Schools, Medical
Fellowships: See Fellowships
Forensic: See Medical Jurisprudence
Foundations aiding: See Foundations
French Congress of, Oct. 15-17, 41
French medical meeting in 1954, 1460
history, and warfare, [Fulton] *182
history, courses in, Belgium, 873
history, Daniel Drake, 555—ab
history, exhibit on, Md., 1455
history, lectures on, (Pa.) 571; (Chicago) 648
history, myasthenia gravis from 1672 to 1900, [Viets] *1273
history of our time, survey by Dr. J. Seide, Israel, 970
history, ophthalmologic journalism in America, 1862-1952, [Adler] *1358; 1365—E
history, Seventh International Congress of History of Science, Israel, 745; 970
history, treatment of tuberculosis 50 years ago, [Placak] *795
Industrial: See Industrial Health
Internal: See Internal Medicine
Law in relation to: See Medical Jurisprudence
Lectures on: See Lectures
Legal: See Medical Jurisprudence
magic, and religion, London, 971
"March of Medicine" television series, 494; 858
medicosurgical meeting (Italy) 1037; (Chile) 1565
Military: See Korean War; Military Medicine
Moving Pictures Concerned with: See Moving Pictures
Organized: See American Medical Association; Societies, Medical
Physical: See Physical Medicine
Practice: See also Licensure; Malpractice; Medical Service; Obstetrics; Physicians, practicing; Specialties
Practice, Emergency Calls: See Emergency
practice (general), American Academy of, Idaho, 1454
practice (general), preparation for, *130
practice (general), psychiatry in, London, 972
practice (general), review by B.M.A., England, 1195
practice (general), teaching important aspects of, London, 660
practice (general), teamwork in, London, 972
practice, group practice study: American Association of Medical Clinics, (report) 955
practice (private) in small industry, [Rieke] *198; [Hughes] *1438
practice, rating communities for establishing a practice, (Council report) 236
Practice, Opportunities for: See Physicians, positions open
practice, type of, 25 years after graduation, Glasgow U. survey, 972
Preventive: See Preventive Medicine
Prizes in: See Prizes
Profession of: See Physicians; Surgeons
progress, statement by Dr. McCormick before U. S. House committee, 730
Psychosomatic: See Psychosomatic Medicine
Quackery: See Quackery
Research in: See Research
Scholarships: See Scholarships
School of: See Schools, Medical
Socialized, National Health Service: See National Health Service, England
socialized, specter of nationalization, London, 446
socialized, The Commonwealth medical benefits scheme, Australia, 231
Societies: See Societies, Medical
Specialization: See Specialties
today's, in underdeveloped areas, [Bowers] *1167
Tropical: See Tropical Medicine
Women in: See Nurses and Nursing; Physicians, women; Students, Medical, women
MEDICINE AND THE WAR: See Medical Preparedness
MEDICINES: See Drugs; Self-Medication
MEDICOLEGAL: See Medical Jurisprudence; Medicolegal Abstracts at end of letter M
MEDICOSURGICAL: See Medicine; Surgery
MEDULLA Spinalis: See Spinal Cord
MEETINGS: See American Medical Association; Societies, Medical; list of Societies at end of letter S
MEGACOLON: See Colon
MEGALOBLADDER: See Bladder
MELAMINE RESIN
allergic contact dermatitis from, [Conrad & Ford] *557
MELANOMA
treatment, bilateral adrenalectomy, [Barker] 1319—ab
MELENA
massive, [Rives] 1315—ab
rupture of aortic aneurysm into esophagus with, [Calenda & Uricchio] *548; [Baer] 1571—C
MELLON LECTURE: See Lectures
MELMAC CAST
allergic contact dermatitis from, [Conrad & Ford] *557

V 15 1953

MEMORIAL
Lectureship: See Lectures
to Physicians: See Physicians, memorial; Prizes
MEN: See Male (cross reference)
in Service: See Armed Forces; Army, U. S.; Navy, U. S.; Servicemen; Veterans
MENADIONE
U.S.P., N.N.R., (Lincoln) 1363
MENDEL and Osborne Medal: See Prizes
MENIERE'S Disease: See Vertigo, aural
MENINGES
fatal reaction to ethyl iodophenylundecylate, [Erickson & van Baaren] *636
hemorrhage, ligate external carotid artery for, [Raney & others] *1434
hemorrhage (spontaneous subarachnoid), surgery for, [Dowling] 1407—ab
Hernia of: See Meningocele
Tuberculosis: See Meningitis, tuberculous
MENINGITIS: See also Arachnoiditis; Meningoencephalitis; Peripachymeningitis
cerebrospinal epidemic, penicillin for, [Izar] 1591—ab
children with, study of 195, Mexico, 446
Meningococcic: See Meningitis, cerebrospinal
tuberculous, after tuberculous pericarditis, streptomycin cures, [Acebo] 887—ab
tuberculous, and streptomycin, Belgium, 1111
tuberculous, chemotherapy, [USPHS] 760—ab
tuberculous, 5 year follow-up, [Smith] 514—ab
tuberculous, hypertrichosis in, [Cetrángolo] 1219—ab
tuberculous, streptomycin and isoniazid for, [Ritchie] 1223—ab
tuberculous, streptomycin in spinal fluid of patients, [Pani] 688—ab
tuberculous, treatment, Sweden, 507
MENINGOCELE
congenital spinal, [Jaeger] *792
intrathoracic, [Baker] 66—ab
MENINGOCOCCEMIA
treatment, arterenol (nor-epinephrine), [Uhl] 1052—ab
MENINGOCOCCUS
Meningitis: See Meningitis, cerebrospinal
Septicemia: See Meningococcemia
MENINGOENCEPHALITIS
mumps, [Bowers] 686—ab
MENOPAUSE
syndrome and vitamin E, [Blatt] 237—ab
treatment of symptoms, 456
MENSTRUATION
Cessation of: See Amenorrhea; Menopause
cycle in baboon, relation to thyroid, [Gillman] 1322—ab
effect of antihistamines on coagulation time, 1229
safe period, calculators for applying Ogino-Knaus theory, (Council report) *32
MENTAL DEFECTIVES: See Epilepsy; Idiocy
MENTAL DISORDERS: See also Alcoholism; Dementia Precox; Epilepsy; Psychoses
Association for Research in Nervous and Mental Disease, meeting, 1292
Hospitalization in: See Hospitals, psychiatric
statistical data, Italy, 506
treatment, contraindications to electric shock, 607
treatment, electric shock, fatal heart rupture during, [Malamud] 1578—ab
treatment, lobotomy, prognosis, Sweden, 1559
treatment of mental illness by topectomy (film review), 1044
treatment, prefrontal lobotomy: follow-up of 125 patients, [Kryger] 1060—ab
treatment, procaine hydrochloride prefrontal injection, [Myers & others] *1015
treatment, prolonged sleep (hibernation method) [Deschamps] 767—ab
treatment, sleep therapy and cure by sleep, [Delay] 1590—ab
MENTAL HEALTH
A.M.A. Committee on, (1st annual report) 930; (Joint Conference, Oct. 24-25) 931; 1024
Association, Juneau, Alaska, 1558
award to Baltimore Sun papers: "mental health bell" Md., 154
board, Okla., 1370
campaign, N. Y., 1456
clinics, Maine, 649
director wanted, Pa., 222
lectures on at New York Academy, 865
National Advisory Mental Health Council, appointments to, 872
National Association for, 739
MENTAL HOSPITALS: See Hospitals, psychiatric
MENTAL HYGIENE: See Mental Health
MENTAL STRESS: See Stress
MENTAL SUGGESTION: See Hypnosis; Psychotherapy
MEPACRINE: See Quinacrine
MEPERIDINE (Demerol; Pethidine)
hydrochloride intravenously before gastroscopy, [Umech & Wirts] *1004
MEPHENESIN (Myanesin; Tolserol)
N.N.R., (American Pharmaceutical; Gold Leaf Pharmacal), 727
treatment of hemiplegia, [Rigoletti] 68—ab
MEPIPERPHENIDOL BROMIDE (Darstine)
name accepted by Council, 801
*di*MERCAPTOPROPANOL: See Dimercaprol
MERCURY
bichloride poisoning, BAL for, [Dósolan] 1053—ab
diuretics, detecting salt depletion during cardiac therapy, [Silverman] 64—ab
diuretics, hypoalbuminemia in complications from, [Diengott] 252—ab
poisoning in industry, 909—ab
METABOLISM: See also under names of specific substances
basal, low rates and thyroid medication, follow-up study, [Kountz] *781
effects of cortisone, Italy, 1467
in paraplegia, [O'Connell & Gardner] *706
National Institute of Metabolic Diseases, (Dr. Daft succeeds Dr. Wilder) 744
METALS: See Copper; Gold; Iron; Lead
METASTASES: See Cancer; Tumors
METEOROLOGY
fulminant pulmonary embolism meteorotropic? [Berg] 885—ab
METHANTHELINE (Banthine)
treatment of congenital hyperhidrosis, [Carson] 1212—ab
treatment of infantile pylorospasm, [Levy] 245—ab
METHAPYRILENE HYDROCHLORIDE
N.N.R., (Chemo Puro) 727
METHAZOLAMIDE-SULFONAMIDES
N.N.R., (Lloyd & Dabney) 1363
METHERGINE Tartrate: See Methylergonovine Tartrate
METHIUM: See Hexamethonium
METHONIUM
Hexamethonium: See Hexamethonium
salts in hypertension, [Grob] 1123—ab
METHORPHINAN HYDROBROMIDE: See Racemorphan Hydrobromide
METHOSTAN: See Methylandrostenediol
METHYLANDROSTENEDIOL (Methostan; Stenediol)
action on growth in children, [Netter] 1592—ab
METHYLBENZETHONIUM CHLORIDE
N.N.R., (Chemo Puro) 1363
METHYL-BIS (BETA-CHLOROETHYL) AMINE Hydrochloride: See Nitrogen Mustard
METHYLENEBIS (Hydroxycoumarin): See Bishydroxycoumarin
METHYLERGONOVINE TARTRATE (Methergine Tartrate)
name accepted by Council, 801
METRAZOL: See Pentylenetetrazole
MEXICO
pinta identified in, [Edmundson] 58—ab
pinta in: mass survey, [Edmundson] 58—ab
MICHIGAN
University of: See University
MICROCOCCUS: See Staphylococcus
MICROORGANISMS: See Bacteria
MICROSCOPY
capillary, of skin diseases, Norway, 1471
MICROTHERMY: See Diathermy
MIDDLE AGE: See Age
MIDWIFERY: See Obstetrics
MIGRAINE: See also Headache
in children, [de Wit] 1447—ab
MILIBIS: See Glycobiarsol
MILITARY: See also Armed Forces; Army, U. S.; Aviation, U. S. Air Force; World War II
medical research, academic freedom in, [Karsner & Phillips] *1356
medicine, Chairman's address [Kern] *457
medicine, warfare, and history, [Fulton] *482
Personnel: See Servicemen
Preparedness: See Medical Preparedness
requirements for physicians, 432—E; 840; 1022—E
service, credit for, *390
Surgeons, Association of, to meet in Washington, 964
universal military training, (Council report) 841
MILK: See also Cheese
cow's, withheld from newborn to prevent allergic disease, [Glaser & Johnstone] *620
dry, nonfat, preparation in treatment of obesity, [Spies] *188
good, campaign for, organized by Belgium Red Cross, 873
Human: See Infants, feeding; Lactation
protein treatment of kwashiorkor, (Council article), [Williams] *1284
skim, powders and experimental caries, [McClure] 174—ab
solid supplement to improve nutrition of children, [Spies] *186
sunlight flavor in, 1076—ab
vitamin D fortified, Council statement, 645
MILK LEG: See Phlegmasia cerulea dolens
MINERAL: See also Copper; Gold; Iron; Lead
deficiencies, effect on amino acid utilization, [Frost] 174—ab
springs, [Kornbluch] 1208—ab
trace elements in brucellosis, (Council article), [Berman] *643
MINERS
hazard of work in uranium mine, 692
to build 10 hospitals, 438
MIRYACHIT
Gilles de la Tourette's disease, (reply) [Yap] 528
MISCARRIAGE: See Abortion
MISSISSIPPI
University of: See University
MISSOURI
physicians placement activities, 1522—E
University of: See University
MITCHELL, SILAS WEIR (1829-1914)
medicine, warfare, and history, [Fulton] *482
MITRAL VALVE
insufficiency (pure) of rheumatic origin, [Movitt] 59—ab
multivalvular heart disease and simultaneous surgical correction, [Bolton] 756—ab
regurgitation, diagnosis, [Abelmann] 677—ab; 729—E
stenosis, Aschoff bodies in auricular appendages, [Decker] 1122—ab; [McNeely] 1209—ab
stenosis, commissurotomy, immediate postoperative results, [Bouvrain] 769—ab
stenosis, commissurotomy in aged, [Janton] 1209—ab
stenosis, commissurotomy, International College discuss, Italy, 582
stenosis, commissurotomy, intracardiac exploration in, 760—ab
stenosis, commissurotomy; late results; indications, [Soulié] 769—ab
stenosis, commissurotomy, rheumatic fever reactivated after, [Soloff] 1576—ab
stenosis, diagnosis, [Logan] 69—ab
stenosis, dynamics of circulation in, [Blacket] 1126—ab
stenosis, effect of oxygen on pulmonary circulation in, [McGregor] 879—ab
stenosis, surgical results in 55 cases, [Bayer] 1223—ab
stenosis, valvulotomy for, [Logan] 69—ab; [Husfeldt] 523—ab
stenosis, walking test before decision on mitral commissurotomy, [Lehmann] 1406—ab
thromboembolic disease involving, [Raynaud] 176—ab
MOBILIZATION: See Medical Preparedness
MOBILOMETER
Shedlovsky, to determine viscosity of contraceptives, (Council article) [Gamble] *1019
MODEL Railroads: See Railroads
MOLD: See Yeast
MOLE: See Nevus
Hydatidiform: See Placenta tumors
MOLINA Lecture: See Lectures
MONILIA
urinary tract infection, 1497
MONONUCLEOSIS, INFECTIOUS
treatment, failure of antibiotics, [Walker] 587—ab
MONSTERS
anencephalic: Incidence, 606
separation and survival of xiphopagus twins, [Reitman & others] *1350
surgical separation in craniopagus (Brodie twins), [Grossman & others] *201
MORAL Code: See Ethics, Medical
MORBIDITY: See Disease
Statistics: See Vital Statistics
MORPHINE
evaluation of coronary vasodilators, [Russek & others] *207
profound effect from, 607
MORTALITY: See Accidents, fatal; Death; Fetus deaths; Infants; Maternity; under names of specific diseases
Rate: See Vital Statistics death rate
MOTHERS: See Maternity
MOTION PICTURES: See Moving Pictures
MOTOR VEHICLES: See Automobiles; Medicolegal Abstracts at end of letter M
MOULTON COMMISSION
Citizens Advisory Commission on Medical Care of Dependents of Military Personnel, President's page, 1178
MOUNT EVEREST: See Everest
MOUNTIN, JOSEPH W., memorial volume proposed, 1371
MOUTH: See also Gums; Jaws; Teeth; Tongue
burning sensation in, 1498
dermal sinuses of dental origin, [Gurdin] 594—ab
herpes simplex infections, [Buddingh] 520—ab
pathology, lecture on, N. Y., 737
surgery, Blum award, N. Y., 1457
surgery, instrument for endotracheal anesthesia during, [Barton] *1017; (correction) 1460
surgery, simple device for tracheobronchial aspiration, [Emerson] *920
MOVING PICTURES: See also Television
A.M.A. Committee on Medical Motion Pictures; See American Medical Association
prize for medicosurgical films by Faculté de Médecine de Paris, 1293
MOVING PICTURES, MEDICAL (REVIEWS)
Baby Care: Feeding, 1117
Fred Bauer Waltz, 1308

MOVING PICTURES, MEDICAL (REVIEWS)—Continued
Frustrating Fours and the Fascinating Fives: Ages and Stages Series, 1202
Lease on Life, 878
Man in the Window, 1117
Principles of Fracture Reduction, 1308
Retire to Life, 1477
School Health in Action, 1367
Surgical Treatment for Congenital Pulmonary Valvular Stenosis, 878
Treatment of Mental Illness by Topectomy, 1044
Warning Shadow, 1573
Your Doctor, 831
MUCOCELE
of lung from congenital obstruction of segmental bronchus, [Ramsay] 590—ab
MUCOPOLYSACCHARIDES
role in aortic atherosclerosis, [Taylor] 1479—ab
MULTIPHASIC Screening: See Diagnosis
MULTIPLE
Births: See Twins
Sclerosis: See Sclerosis, Multiple
MUMPS (epidemic parotitis)
in adult males, gamma globulin allocated for, 74
meningiencephalitis, [Bowers] 686—ab
treatment, convalescent blood, 1496
MURDER
medicolegal experiences under Ohio coroner's system, [Landé & Boone] *1479
MUSCLES
Atrophy: See Atrophy
blood flow, radiosodium clearance to determine, [Wisham & others] *10
Cardiac: See Myocardium
Cramps: See Cramps
disease, thyroid relation to, [Millikan] 585—ab
Dystrophy: See Dystrophy, muscular
Exercising: See Exercise, therapeutic
Exertion: See Effort
musculoskeletal deformity after poliomyelitis, physician's role in preventing, [Bennett] *79
pubococcygeus, and sexual physiology of vagina, Kinsey report, [Kegel] 1303—C
relaxants, report on by A.M.A. Council, 800
rigidity, carbon dioxide inhalation for, (correction) 225; (vs. psychotherapy) [Leavitt] 509—C
Spasm: See Spasm
Sphincter: See Sphincter Muscles
Strength, Decrease of: See Myasthenia Gravis
Tonus: See Dystonia
unexplained swellings, 692
MUSCULAR DYSTROPHY: See Dystrophy
MUSEUM: See Health museum
of Science and Industry Lectures: See Lectures
MUSIC
as therapeutic modality, 219—E
Orchestral: See Physicians, avocations
MUSTARD
Nitrogen: See Nitrogen Mustard
MYALGIA
Epidemic: See Pleurodynia, Epidemic
MYANESIN: See Mephenesin
MYASTHENIA GRAVIS: See also Dystrophy, muscular
complicating pregnancy, [Fraser] 1222—ab
congenital, [Walker] 1046—ab
historical review (1672-1900) [Viets] *1273
incidence and remission: sex and age as factors; role of thymus, [Schwab & Leland] *1270
malignant thymoma in, [Katz] 520—ab
thyroid in relation to, [Millikan] 585—ab
treatment, carotid sinus denervation, [Thevenard] 170—ab
treatment, course and management, [Grob] *529
treatment, pyridostigmine, [Seibert] 175—ab
treatment, thymectomy, [Schwab & Leland] *1270
MYCOBACTERIUM Tuberculosis: See Tubercle Bacillus
MYCOSIS: See also Actinomycosis; Blastomycosis; Tinea capitis
of feet, prevention, 1068
MYELITIS: See Encephalomyelitis; Poliomyelitis; Spinal Cord inflammation
MYELOGRAPHY: See Spinal Canal
MYELOMA
multiple, occurring in jaws, [Bruce] 247—ab
multiple, total protein vs. globulin value in, 1598
spinal cord compressed by, surgery for, [Svien & others] *784
MYELOPATHY: See Spinal Cord disease
MYELOSCLEROSIS
following polycythemia, [Beattie] 1217—ab
MYOCARDITIS
in poliomyelitis, [Teloh] 56—ab
in rheumatic fever, [Saphir] 1400—ab
MYOCARDIUM
disease (primary) in infancy and childhood, [Rosenbaum] 976—ab
experimental vascularization of heart muscle, [Wendt] 1405—ab
Infarction: See also Thrombosis, coronary
infarction, 693
MYOCARDIUM—Continued
infarction, anticoagulants in, [Schnur] 168—ab; [Furman] 239—ab; [Green] 1404—ab
infarction: premonitory symptoms, [Bledsoe] 50—C
infarction, psychic factors in pathogenesis, [van Balen] 1489—ab
Inflammation: See Myocarditis
sarcoidosis, [Sales] 518—ab
MYOSITIS
Epidemic: See Pleurodynia, Epidemic
MYOTONIA
Dystrophica: See Dystrophy, muscular
MYSOLINE: See Primidone
MYVIZONE: See Amithiozone
MYXEDEMA
Congenital: See Cretinism
heart after thyroidectomy; advanced failure with rapid recovery, [Weyher] *639
hypercholesterolemia and atherosclerosis, [Blumgart] 239—ab
I[131] induced, heart in, [Kurland] 1052—ab
MYXOMA
viruses and vaccinia, morphology of compared, [Farrant] 1057—ab

Medicolegal Abstracts

BLOOD
paternity; blood grouping tests, 1572
transfusions; hepatitis, 674—E
transfusions; irradiation of plasma, 674—E
transfusions; jaundice, 674
transfusions; labeling requirements relative to plasma, 674
transfusions; plasma distributed by State; liability for untoward results, 674
CHIROPODY
equipment defective; injury from, 751
CHIROPRACTIC
diets; prescribing, when lawful, 750
interstate commerce in relation to practice, 1309
Sherman Anti-Trust Act in relation to, 1309
DRUGS
fennel; as constituting, 750
foods; as constituting, 750
sage; as constituting, 750
vitamins; as constituting, 1044
DRUNKENNESS
chemical tests; admissibility, (correction) 439
EVIDENCE
blood grouping tests; paternity, 1572
drunkenness, chemical tests, (correction) 439
paternity; blood grouping tests, 1572
scientific tests; drunkenness, (correction) 439
scientific tests; paternity, 1572
FOODS
drugs; when considered as, 750
HEPATITIS
blood transfusion as cause of, 674
HOSPITALS, IN GENERAL
care; degree required, 750
equipment; adjustable chair; patient injured, 750
taxes; criteria of nonprofit status, 447
INSURANCE, ACCIDENT
total disability; criteria, 1117
INSURANCE, HEALTH
physicians; total disability in relation to, 1117
total disability; criteria, 1117
INSURANCE, INDEMNITY
malpractice; defective equipment, injury from, 751
JAUNDICE
blood transfusion as cause of, 674
MALPRACTICE
childbirth; delayed attendance on patient, 1476
chiropodist; equipment defective causing injury, 751
equipment; injury to patient from, 751
obstetrician; care and skill required, 1476
placenta; failure to attend separation promptly in obstetrical case, 1476
skill and care; standards; obstetrician, 1476
MEDICAL PRACTICE ACTS
diets; prescribing, when lawful, 750
"Dr."; use of title by naturopath, 164
naturopathy; advertisements; use of title "Dr.", 164
Sherman Anti-Trust Act in relation to medical practice, 1309
MOTOR VEHICLES
drunken drivers; chemical tests, (correction) 439
NATIONAL FORMULARY
judicial notice, 750
NATUROPATHY
"Dr."; use of title as evidence of medical practice, 164
PHARMACY PRACTICE ACT
constitutionality, 1044
vitamins; restriction of sale to pharmacists, 1044
QUARANTINE
tuberculosis; validity of statute, 878
SCIENTIFIC TESTS: See Evidence
SHERMAN ANTI-TRUST ACT
chiropractic; practice as interstate commerce, 1309
medicine; practice as interstate commerce, 1309

Medicolegal Abstracts—Continued

TAXES
federal income; business expenses; ordinary and necessary, 511
federal income; postgraduate study; cost as business expense, 511
hospitals; criteria of exemption, 447
TUBERCULOSIS
quarantine; validity of statute, 878
U. S. PHARMACOPEIA
judicial notice, 750
VITAMINS
as drugs, 1044
WORDS AND PHRASES
"arising out of the practice," 751
"drugs," 750; 1044
"profit," 447
"proprietary medicines," 1044
"total disability," 1117
"Trade or Commerce," 1309

N

N.H.S.: See National Health Service
N.N.R.: See American Medical Association; under names of specific products
NAILING
Küntscher's Method: See Fractures, treatment
NALLINE HYDROCHLORIDE: See Nalorphine Hydrochloride
NALORPHINE HYDROCHLORIDE (N-Allylnormorphine; Nalline)
treatment of racemorphan (dromoran) intoxication, [Domino & others] *26
NAPHAZOLINE HYDROCHLORIDE (Privine)
U.S.P.-N.N.R., (Ciba) 1363
NARCOSIS: See also Anesthesia
artificial hibernation differentiated from induced hypothermia, [Dogliotti] 1225—ab
artificial hibernation in acute coronary thrombosis, Paris, 877
artificial hibernation in acute delirium, 1197
artificial hibernation in bronchopneumonia, France, 1197
artificial hibernation in neurotoxic condition in infants, France, 1197
artificial hibernation in scarlet fever, France, 1196
induced sleep in poliomyelitis, [Brehme] 1060—ab
prolonged sleep (hibernation) in psychiatric treatment, [Deschamps] 767—ab
sleep cure and sleep therapy, [Delay] 1590—ab
treatment of epilepsy, (correction) 573
NARCOTICS: See also Morphine
addiction problems, Denmark, 1300
NASAL: See Nose
Sinusitis: See Sinusitis, Nasal
NASOPHARYNGITIS: See Colds
NASOPHARYNX: See Adenoidectomy
NATION
President's Commission on Health Needs of the Nation: See President's Commission
NATIONAL: See also American; International; list of Societies at end of letter S
Advisory Cancer Council, 580
Advisory Heart Council, appointments, 580
campaign against typhus, Mexico, 1113
Citizens Committee for Educational Television, report, 1459
Commission on Accrediting, (report) 941
Committee on Radiation Protection, [Chamberlain] *488
Conference on Care of Long-Term Patient, (President's page) 857
Conference on Mental Health, 931; 1024
Conference on Physicians and Schools (4th), 151; 853; 858
Congress for Protection of Children, Mexico, 1568
Congress of Gastroenterology, Colombia, 1037
Defense: See Armed Forces; Civilian Defense; Medical Preparedness
Education Campaign of A.M.A.: See American Medical Association
Emergency Medical Service, A.M.A. Council on: See American Medical Association
Formulary: See Medicolegal Abstracts at end of letter M
Foundation for Infantile Paralysis: See Foundations
Fund for Medical Education: See Foundations
Health Service (England), (specter of nationalization) 446; (private patients' prescriptions) 446; (anniversary; statistics covering services) 506; (tuberculosis hostels) 662; (dentists and) 874; (review of general practice under, by B.M.A.) 1195; 1302; (financial and medical reports) 1300; (hospital priority for war pensioners) 1378; (clinical research in) 1378; (insuring hospital independence) 1568; (plea for decentralization of hospital control) 1567
Immunization week, 225
Institute of Arthritis and Metabolic Diseases, Dr. Daft succeeds Dr. Wilder, 744
Institutes of Health: See Health
Insurance Scheme, new maternity benefits under, London, 1378

V 1
195

NATIONAL—Continued
Intern Matching Plan, (Council report) *279; 943
Meeting of Colombian Obstetricians and Gynecologists (first), 1037
Research Council, (apply for medical research fellowships) 439; (statement of Dr. McCormick before U. S. House Committee) 730
Safety Council; (annual report: "Accident Facts") 571; (congress sponsored by) 652
Science Foundation: See Foundations
NATUROPATHY: See Medicolegal Abstracts at end of letter M
NAUSEA
treatment, new drug: Compound 2661-A, [Friend & Cummins] *180
NAVY, UNITED STATES: See also Armed Forces
annual symposium in first and fourth districts, 46
aviation medicine, course in, 46
guest lecture series, 259
Hospitals: See Hospitals, Naval
medical and dental symposium, 161; 504
medico-military matters, course in, 504
reserve personnel, courses for, 504; 1194
reserve unit, new type, 1466
Surgeon General's symposium, 968
NECK
flushing in woman, 1497
tuberculous lymphoma, [Stiefel] 1061—ab
vagal body and its tumor, [Birrell] 1320—ab
whiplash injuries, [Schaefer] 874—C
NECROLOGY: See Deaths at end of letter D
NECROPSIES: See Autopsies
NECROSIS: See also Kidneys; Liver; Pituitary
hydrocortisone and resistance of tissue to injury, [Nettleship] 1040—C
necrotic arachnidism, [Mackinnon] 1582—ab
superficial, streptokinase-streptodornase in enzymatic decortication, [Halse] 687—ab
NEEDLE
Biopsy: See Liver
Luer-hub, coupling device for polyethylene catheter, [Alman & Whriskey] *562
NEEDY: See Medically Indigent
NEGROES
congenital hemolytic anemia in brothers, [Irby] *103
diagnostic significance of blood sugar findings, [McLaughlin & others] *182
medical students, *126
skin pigmentation in inter-marriage, (reply) [Whipple] 894
NEISSERIA
revision of chromogenic strains, Brazil, 1376
NELSON LABORATORY
opened in Vienna, 867
NEOANTERGAN: See Pyrilamine Maleate
NEOMYCIN
Combined with Bacitracin: See Bacitracin-Neomycin
erythromycin ointment for skin infections, [Livingood & others] *1266
Intestinal antiseptic, also combined with phthalylsulfathiazole, [Poth] *1516
treatment to control surgical infections, [Meleney & Johnson] *1253
NEOPLASMS: See Cancer; Sarcoma, Tumors; under region or organ affected
NEOSTIGMINE (Prostigmine)
bromide treatment of myasthenia gravis, [Grob] *501
bromide-U.S.P., N.N.R., (Hoffmann-La-Roche) 727
methylsulfate-U.S.P., N.N.R., (Lincoln Laboratories) 727
treatment of muscle spasm in arthritis, [Howell] 1583—ab
NEPHRITIS
A.M.A. Section on Experimental Medicine and Therapeutics, symposium on recent advances in, [Corcoran] *1233; [Luetscher & others] *1236; [Keith & Odell] *1240; [Goldring] *1245
glomerular, outlook for patients with, [Keith & Odell] *1240
pregnancy advisable? 608
radiation, [Loxton] 525—ab
NEPHROLITHIASIS: See Kidneys calculi
NEPHRON Nephrosis: See Kidneys, disease
NEPHROPATHIA Epidemica: See Kidneys, disease
NEPHROSIS: See Kidneys, disease
NEPRESOL
hypertension treatment, [Kummer] 887—ab
NERVES: See also Nervous System; Neuracoustic, damage from streptomycin, 990
acoustic, tumors, trigeminal symptoms, [Cleveland] 1579—ab
Anesthesia: See Anesthesia
Block (sympathetic): See Nervous System, Sympathetic
disease, thyroid relation to, [Millikan] 585—ab
Ganglion: See Ganglion
Paralysis: See Paralysis
Reflex: See Reflex
Roots: See Guillian-Barré Syndrome; Neurons
supply of bladder, [Van Duzen & Duncan] *1345
Surgery: See under subheads of Nerves; Neurosurgery
NERVES—Continued
Sympathetic: See Nervous System, Sympathetic
Syphilis: See Neurosyphilis
terminal corpuscles in walls of arteries and veins, Italy, 1038
vagotomy, clinical observations, [Mandl] 596—ab
vagotomy effect on gastric evacuation of high-fat meals, [Waddell] 61—ab
vagotomy vs. gastric resection in peptic ulcer, [Walters & Chance] *993
NERVOUS INDIGESTION: See Indigestion
NERVOUS SYSTEM: See also Brain; Ganglion; Nerves; Nervous System, Sympathetic; Spinal Cord
Disease: See Encephalomyelitis
experimental ethylism, Paris, 663
mechanism of sensitization eczema, [Charpy] 1708—ab
neurotoxic condition infants, artificial hibernation in, England, 1197
Surgery: See subheads under Nerves; Neurosurgery; Sympathectomy
Syphilis: See Neurosyphilis
NERVOUS SYSTEM, SYMPATHETIC
block in pancreatitis, (Brancodoro) 984—ab
block in shoulder-hand syndrome, [Steinbrocker & others] *788
epidemic (?) in crisis (Fez) 1594—ab
Surgery: See Sympathectomy
NEURALGIA: See also Causalgia
chronic, after herpes zoster, treatment, 456
facial, massive doses of vitamin B_{12} in, [Lereboullet] 601—ab
intercostal, death after using efocaine, [Angerer & others] *550
trigeminal symptoms in acoustic nerve tumors, [Cleveland] 1579—ab
NEURITIS
polyneuritis, massive doses of vitamin B_{12} in, [Lereboullet] 601—ab
toxic peripheral, from chemical reagents used in dry cleaning, 1232
NEUROBLASTOMA: See Sympathicogonioma
NEURODERMATITIS
prevention in newborn by withholding cow's milk from diet, [Glaser & Johnstone] *626
treatment, inject acetylcholine and epinephrine, [Lobitz] 512—ab
NEUROLOGY: See also Nerves; Nervous System; Neurosurgery
American Board of: See American Board
Association for Research in Nervous and Mental Disease, meeting, 1291
conditions, massive doses of vitamin B_{12} in, [Lereboullet] 601—ab
history, of A.M.A. Section, [Forster] *609
pediatric, fellowship available, Chicago, 1027
Surgery in: See Neurosurgery
NEUROMUSCULAR: See Muscles; Nerves
NEURONITIS
Infectious: See Guillain-Barré Syndrome
NEURONS
cervical avulsion from spinal cord; hemilaminectomy, [Jaeger & Whiteley] *633
disease (diffuse), myoclonus epilepsy in, [Watson] 1120—ab
NEUROPATHY
Ar hritic: See Charcot's Joints
diabetic, [Hirson] 685—ab
in tuberculous patients from isoniazid, [Gamman] 1746—ab
NEUROPSYCHIATRY
Neuropsychiatric Institute, new name for Village for Epileptics, N. J., 1456
NEUROSIS
Montebello Sanatorium for, Denmark, 581
vegetative, epidemic? [Fog] 1594—ab
NEUROSURGERY: See also Brain surgery; Nerves; Sympathectomy
American Board of Neurological Surgery; See American Board
Congress of Neurological Surgeons, meet in New Orleans, 964
for compression of spinal cord caused by myeloma, [Svien & others] *784
NEUROSYPHILIS: See also Tabes Dorsalis
treatment: arsphenamine, bismuth, penicillin, [Verjaal] 1224—ab
treatment, malaria vs. penicillin; blood and spinal fluid test for reagin, [Thomas] *718
treatment, penicillin G, [Dammann] 1322—ab
NEUTRON RAYS: See Cyclotron
NEUTROPENIA: See also Agranulocytosis
cyclic at 21-day intervals, splenectomy for, [Coventry] *28
NEVUS
hemangiomatous, conservative treatment, [Wallace] 1058—ab
pigmented moles, 1416
spontaneous involution birthmark, [Ronchese] 1575—ab
NEW AND NONOFFICIAL REMEDIES: See American Medical Association; and under names of specific products
NEW ENGLAND
Center Lectures: See Lectures
NEW GROWTH: See Tumors
NEW YORK
Heart Association, (study of blood pressure in those 65 and over) [Master] 1115—C; (use of term "atrium" for "auricle") [Hyman] 1304—C
NEWBORN: See Infants, Newborn
NEWSPAPERS: See also Journals
Baltimore Sunpapers awarded "mental health bell," Md., 154
blood transfusion accidents written up in, pathologists' group report, London, 875
NIADRIN: See Isoniazid
NICOLAS-Favre-Durand Disease: See Lymphogranuloma, Venereal
NICOTINE: See Tobacco
NICOTINIC ACID: See Acid, nicotinic
NIGHT BLINDNESS
congenital, [Carroll] 586—ab
NIPPLE: See Breast
NISENTIL: See Alphaprodine Hydrochloride
NITRITES
octyl nitrite, coronary vasodilators evaluated, [Rueck & others] *207
NITROGEN MUSTARD
treatment of Hodgkin's disease, 774
NITROGLYCERIN: See Glyceryl Trinitrate
NOCARDIOSIS
brasiliensis, effect of DDS on, Mexico, 446
portal of entry: treatment, [Hickey] 1478—ab
NODES: See Heberden's Nodes
NODULES
in tendons of hands, 258
NOISE
abatement symposium, 572
bruit in left ear, 1231
in industry, [Walmer] 60—ab
NOISES in the Head: See Tinnitus
NOMENCLATURE: See Terminology
NOR-EPINEPHRINE: See Arterenol
NORMAN (Hazett) Prize: See Prizes
NORTH CAROLINA
University of: See University
NOSE: See also Otorhinolaryngology
Accessory Sinuses: See Sinusitis, Nasal
blastomycosis in tuberculous, [Stillians & Klemptner] *560
chrome ulcer and perforated septum (Council article), [Walsh] *1306
Colds: See Colds; Hay Fever
granuloma (lethal), corticotropin in, [Hagens] 165—ab
medication in coronary patients, 178
NUCLEAR POWER: See also Atomic Energy
reactor at state college, N. C., 1104
NUCLEUS
Pulposus: See Spine, intervertebral disk
NUMBNESS
facial, symptom in acoustic tumors, [Cleveland] 1579—ab
NURSES AND NURSING
A.M.A. Committee for Study of Nursing Shortage, [Murdock] *1442
Books concerned with: See Book Reviews at the end of letter B
Committee on Accreditation of Nursing Schools, [Murdock] *1443; *1444
nonresident hospital nurses, London, 747
NURSING HOMES
standardization important, [Murdock] *1442
NURSLINGS: See Infants
NUTRITION: See also Diet; Food; Infants, feeding
A.M.A. Council on Foods and Nutrition: See American Medical Association
Borden award, 1292
Day, Michigan, 569
Deficiency: See Pellagra; Vitamins, deficiencies
disorder, kwashiorkor, (Council article) [Williams] *1280
Drummond Research Fellowship, London, 874
Foundation, Inc., Osborne and Mendel award, 1187
Goldberger Award, (in 1952) 939; (to Dr. McLester in 1953) 1367
in older persons, [Kountz] *781
process affected by cortisone acetate and corticotropin, [Spies] *193
processes, effect of pregnancy, lactation, growth and aging on, [Spies] *185
undernourished children, Welzel grid of, [Spies] *187
undernutrition and overnutrition, 1364—E
Vitamins in: See Vitamins
NYCTALOPIA: See Night Blindness
NYDRAZID: See Isoniazid
NYSTAGMUS
congenital, no treatment available, 455

O

OMPA: See Octamethyl Pyrophosphoramide
OATH OF HIPPOCRATES
reproduced, 733
OBESITY
as diencephalohypophysial dysregulation, [Kossmann] 1127—ab
basic considerations of, [Jolliffe] 880—ab
coronary disease and hypertension relation to, [Master & others] *1499
does not mean overeating, [Klotz] 453—ab
overnutrition and undernutrition, 1364—E
Silkworth Memorial Service of Knickerbocker Hospital, N. Y., 1558
treatment with nonfat dry milk preparation, [Spies] *188
OBITUARIES: See list of Deaths at end of letter D

153
953

OBSESSIVE-COMPULSIVE REACTION
treated with prefrontal procaine injection, [Myers & others] *1015
OBSTETRICS: See also Abortion; Cesarean Section; Labor; Pregnancy; Puerperium
American Board of: See American Board
Anesthesia in: See Anesthesia
lectures on, N. C., 737
modern, place of forceps in, 1450—E
national meeting of Colombian obstetricians, 1037
OCCIPITAL BONE
assimilation of atlas to, [McRae] 588—ab
OCCUPATIONAL
Dermatoses: See Industrial Dermatoses
Disease: See Industrial Diseases
Health: See Industrial Health
OCCUPATIONAL THERAPY
therapists meet in Houston, Nov. 13-20, 964
value in peptic ulcer, [Ehrlich] 881—ab
OCTAMETHYL PYROPHOSPHORAMIDE
treatment of generalized myasthenia gravis, [Grob] *531
OCTYL NITRITE: See Nitrites
OCULAR Symptoms: Tests: See Eyes; Vision
ODDI'S Sphincter: See Sphincter Muscles
ODOR
chlorophyll and deodorization, 728—E; [Westcott; Ryan; Langley] 749—C; [Hein] 1571—C
of paint and asthma, 258
of swimming pool water, 178
OFFICE: See Physicians
OFFICE PLAQUE
"To all my patients," 152
OFFICERS: See Armed Forces; Army, U. S.; Aviation, U. S. Air Force; Health, U.S.P.H.S.; Medical Preparedness; Navy, U. S.
of A.M.A.: See American Medical Association
OGINO-KNAUS THEORY
calculators for applying, (Council report) *32
OHIO: See also Toledo
coroner's system, medicolegal experiences under, [Landé & Boone] *179
OIDIUM (Candida) albicans: See Monilia
OIL
Iodized: See Iodized Oil
oily hair in white women, 607
OINTMENT: See Eyes; Neomycin
OLD AGE: See also Life duration
asymptomatic fractures in osteoporotic spines of aged, [Gershon-Cohen & others] *625
burning pain in foot in woman 82, 693
cancer of cervical esophagus and larynx, esophagolaryngectomy (Wookey operation) in, [Lam & Gordon] *552
cardiac arrest, intracardiac puncture in, [Cronkhite] 593—ab
cardiac patients, occupational potentialities, [Bronsztein] 169—ab
diabetes mellitus in aged, 1433—ab
diseases in, and nutritional processes, [Spies] *189
drama in statistics, 1177—E
drug treatment in state mental hospital, [Levy] *1260
elderly more susceptible to anoxia, [May] 1570—C
esophageal obstruction due to Serutan; liquid Taka-diastase for, [Johnson] 235—C
family physician and heart disease, [Mills] *910
geriatric clinic, N. Y., 1370
geriatrics symposium, 968
inguinal hernia in men over 55, [Debenham] 882—ab
insurance, a physician and an economist look at, [Blalngame & Dickinson] *821; 959—E
mitral commissurotomy in aged, [Janton] 1209—ab
Physicians attaining: See Physicians, veteran
potentials of the aging, intensive study, Conn., 1288
surgical risk in, International College of Surgeons discusses, Italy, 582
surgical survival of the aged, 728—E; [May] 1570—C
testosterone for older men, 1598
therapeutic aspects of geriatric medicine, [Kountz] *777
OOPHORECTOMY: See Ovary surgery
OPERATING ROOMS: See Surgery
OPERATION: See Surgery; under names of specific organs and disease
Illegal: See Abortion, criminal
Standard Nomenclature: See Terminology
OPHTHALMIC Ointment; Solutions: See Eyes
OPHTHALMOLOGY: See also Eyes; Vision
American Board of: See American Board
Annual Conference, Calif., 1102; 1183
conference on, Calif., 1556
journalism in America (1862-1953), [Adler] *1358; 1365—E
lectures, Pa., 1105
postgraduate course, N. Y., 1103
school exclusively for, Habana, 1558
seminar, Florida, 1288
OPHTHALMOPLEGIA: See Eyes, paralysis
OPIUM: See Morphine
ORAL Cavity: See Mouth
ORANGE
juice, pain from potassium intoxication in Kimmelstiel-Wilson syndrome, [James & others] *345
ORATIONS: See Lectures
ORBIT
Leukotomy via: See Brain surgery
ORCHESTRA: See Physicians, avocations
ORCHIECTOMY: See Testes surgery
ORGANISMS: See Bacteria; Virus
ORGANIZATIONS: See Societies, Medical; list of Societies and Other Organizations at end of letter S
ORGANIZED LABOR: See Industrial Trade Unions
ORGANIZED MEDICINE: See American Medical Association; Societies, Medical
ORGANS: See Viscera; under names of specific organs as Heart; Stomach
ORGASM
role of pubococcygeus muscle, [Kegel] 1303—C
ORTHOPEDICS: See also Bones; Foot; Fractures
clinic, Calif., 220
course on, Kansas, 735
Surgery, American Board of: See American Board
surgery, international meeting at Bern, Switzerland, 1559
OSBORNE and Mendel Medal: See Prizes
OSTEITIS
pubis, traumatic etiology, [Adams] 1314—ab
OSTEOARTHRITIS: See Joints, degenerative joint disease
OSTEODYSTROPHY
renal, [Dracsted] 690—ab
OSTEOGENESIS imperfecta: See Fragilitas ossium
OSTEOMYELITIS
treatment, streptokinase-streptodornase in empyematic decortication, [Halse] 687—ab
OSTEOPATHLA
hypertrophic, with plasmacytoma of lung, [Plenk] 770—ab
OSTEOPOROSIS
asymptomatic fractures in osteoporotic spines of aged, [Gershon-Cohen & others] *625
OTITIS MEDIA
treatment, antibiotics vs. surgery, [McLaurin] 683—ab
OTOLARYNGOLOGY: See also Larynx
American Board of: See American Board
otolaryngologist wanted in India, 439
OTOLOGY: See also Ear; Otolaryngology; Otorhinolaryngology
seminar, Florida, 1288
OTORHINOLARYNGOLOGY
51st French Congress, 41
OUABAIN
intravenous digitalization, 1496
OVALOCYTOSIS: See Erythrocytes
OVARY: See also Ovulation
aplasia, Turner's syndrome in female, [Jackson] 1217—ab
cysts, twisted pedicles, Brazil, 1376
disorders, diagnostic pneumoperitoneum in, [Kunstadter] 1203—ab
inguinal hernia involving, [Torres Oliver] 1216—ab
surgery, oophorectomy and breast cancer, 1231
OVERLAND Brand Dietetic Pack Peas and Carrots, 1099
OVERNUTRITION: See Nutrition
OVERSEAS: See Foreign Countries
OVERWEIGHT: See Obesity
OVIDUCTS
inguinal hernia involving, [Torres Oliver] 1216—ab
surgery, bilateral salpingectomy, 1142
OVULATION
calculators for applying Ogino-Knaus theory, (Council report) *32
timing conception: use of basal temperature charts, [Tyler] *1354
OVUM: See Embryo
OWREN'S METHOD
of prothrombin-proconvertin determination, [Lund] 602—ab; 662; 876
OXFORD SURVEY
breast-feeding in, [Stewart] 1127—ab
OXYGEN: See also Pneumoperitoneum; Pneumothorax, Artificial
administration and retrolental fibroplasia, [Huggert] 452—ab
deficiency, cardiac arrest and ventricular fibrillation, [Stewart] 586—ab
deficiency, cerebral anoxia and causation of epilepsy, [Courville] 679—ab
deficiency, cerebral anoxia in aged, [Levy] *1260
deficiency, elderly more susceptible to anoxia, [May] 1570—C
deficiency, intrauterine anoxia as cause of fetal death during labor, [Taylor] 522—ab
effect on pulmonary circulation in mitral valve stenosis, [McGregor] 879—ab
insufflation (perirenal), Carelli's technique, [Ritter] 244—ab
Quotient: See Metabolism, basal
supply in ophthalmic diseases, [Blettl] 56—ab
OXYTETRACYCLINE (Terramycin)
intestinal antiseptics, [Poth] *1516
toxicity, [Miller] 1579—ab
treatment of dermatoses, [Robinson] 1213—ab
treatment of diphtheria, [Lall] 592—ab
treatment of nonbacterial respiratory infections, [Jones & others] *262
treatment of pulmonary tuberculosis, [Tempel] 589—ab
treatment of relapsing fever, [Gefel] 765—ab
treatment of severest inflammations, [Schultz] 1489—ab
treatment plus chloramphenicol of multiple lesions in Letterer-Siwe disease, [Fisher] 62—ab
treatment plus thymol in trichomoniasis vaginalis, [Candlani] 1131—ab
treatment to control surgical infections, [Meleney & Johnson] *1253

P

PAM: See Penicillin, procaine
PAS: See Acid, p-aminosalicylic
ph: See Hydrogen Ion Concentration
PHP: See Phenindione
PR: See Public Relations
PAGLANE: See Cyclamine
PAIN: See also Backache; Headache; Neuralgia; under names of specific diseases, organs and regions as Knee; Pancreas; Peptic Ulcer; Rectum; Stomach
Burning: See Causalgia; Erythromelalgia; Sensation
in hemiplegic area, 1416
insensitivity to, causes progressive joint disorders, [Petdie], 1221—ab
lightning, of tabes dorsalis, 606
patterns in gallbladder disease, 629—ab
patterns of gastric and duodenal pain, 556—ab
Precordial: See also Angina Pectoris; Arteries, coronary; Thrombosis, coronary
Relief of: See also Anesthesia
relief of, cordotomy in high cervical region for intractable pain, [French] 682—ab
relief of, selective lobotomy for intractable pain, [Grantham] 167—ab
relief of, with insulin and glucose in potassium intoxication, [James & others] *545
PAINT
odors of, cause of asthma? 258
which ones safe for school children to use? 455
PAINTING: See Art
PALATE
cleft, rhinolalia, 1232
PALESTINE: See Israel
PALSY
Cerebral: See Paralysis, cerebral
Shaking: See Paralysis agitans; Parkinsonism
PAN AMERICAN
Congress of Surgery, Brazil, 162
Sanitary Organization, 1459
PANARIS: See Paronychia
PANCREAS: See also Diabetes Mellitus
cancer (pancreaticoduodenal), [McDermott] 173—ab
cysts, treatment, [Doubilet] 66—ab
extract, correction of asthmatic terrain, [Santenoise] 253—ab
"fibrinoclasis" on emboli of pulmonary arteries, [Zinn] 1592—ab
hyperglycemic glycogenolytic factor of: glucagon, [de Duve] 887—ab
Inflammation: See Pancreatitis
islets of Langerhans, factors affecting, [Halst] 1210—ab
lesions in malignant hypertension, [Hranhovich] 238—ab
pain, 19—ab
Secretions: See Insulin
tumor, insulinoma, spontaneous hypoglycemia from, [dePeyster] 1478—ab
PANCREATITIS
acute, with leptospirosis, Brazil, 1195
treatment, sympathetic intervention, [Brancadoud] 984—ab
PANCYTOPENIA: See Blood cells
PANNICULITIS
nodular, nonsuppurative, cortisone treatment, [Harrison] 246—ab
relapsing febrile nonsuppurative, leprosy as etiological factor, [Birrell] 1223—ab
PANTOPAQUE: See Ethyl Iodophenylundecylate
PAPAVERINE
coronary vasodilators evaluated, [Russek & others] *207
ethyl analogue of: ethaverine in angina pectoris, [Voyles & others] *12
PAPER: See Newspapers
Prizes for Papers: See Prizes
PAPILLOMA
of gallbladder with in situ carcinoma, [Tabah] 521—ab
PARA-AMINOBENZOIC ACID: See Acid, p-aminobenzoic
PARA-AMINOSALICYLIC ACID: See Acid, p-aminosalicylic
PARACOLON BACILLUS (Arizona)
multiple bone lesions in Letterer-Siwe disease, [Fisher] 62—ab
PARADIONE: See Paramethadione

PARAGANGLIOMA: See Pheochromocytoma
PARAGONIMUS Infestation: See Distomiasis
PARALYSIS: See also Hemiplegia; Paraplegia
Agitans: See also Parkinsonism
agitans, antispasmodic compound 08958 for, [Magee & DeJong] *715
agitans, vitamin B_{12} treatment, possible toxic effects? 257
cervical, and pregnancy, 1197
cerebral, educating children with, 651
cerebral palsy, cerebral hemispherectomy in, [Beller] 252—ab
cerebral palsy clinic, Fla., 1102
cerebral palsy course, N. Y., 496
cerebral palsy, meeting on, Calif., 648
cerebral, United Cerebral Palsy Associations, (appoints chairman) 223; (grants by) 734; (meeting) 1027; (grants) 1559
hyperpotassemic, [Bull] 766—ab
Infantile: See Poliomyelitis
of Bladder: See Bladder, neurogenic
of legs in disseminated lupus erythematosus, [Piper] *215
periodic, thyroid relation to, [Millikan] 585—ab
Respiratory: See Poliomyelitis
Spastic: See Paralysis, cerebral
PARAMETHADIONE (Paradione)
toxicity: nephrotic syndrome, [Wren & Nutt] *918
PARANASAL SINUSES: See Sinusitis, Nasal
PARAPLEGIA
metabolism in, [O'Connell & Gardner] *706
myeloma compresses spinal cord, neurosurgery for, [Svien & others] *784
PARASITES
Intestinal: See Teniasis
PARASYMPATHETIC: See Nervous System, Sympathetic
PARATHION
poisoning from anticholinesterase, [Moseley] 1318—ab
PARENTS: See also Maternity; Paternity
television course for, at U. of Michigan, 649; 864; 1184
PARESTHESIA
polycythemia vera, 1415
PARKINSONISM: See also Paralysis agitans
etiology: trauma, 1229
treatment, benzotropine sulfonate, [O'Doherty] 63—ab
PARONYCHIA
treatment (topical) with erythromycin, [Livingood & others] *1266
PAROTID GLAND
cancer in girl of 8, [Salce] 1320—ab
PAROTITIS, EPIDEMIC: See Mumps
PARTNERSHIPS
medical, ideal, Denmark, 1113
PARTURITION: See Labor
PAS: See Acid, *p*-aminosalicylic
PASIMYCIN
treatment in urology, [Strähuber] 1489—ab
PASMED: See Acid, *p*-aminosalicylic, sodium salt
PASTE: See Peruvian Balsam
PATELLA
repair in ruptured tendon with airplane control cable, [Chandler] *1093
PATERNITY
anthropological tests, Sweden, 49
disputed, blood tests in, (Committee report) 837
PATHOLOGISTS
American Society of Clinical Pathologists, meet Oct. 13-16, 572
report on newspaper publicity given to transfusion accidents, London, 875
time required for pathologist to examine tissue sections, 257; (replies) [Wright; Pickard] 1328
PATHOLOGY: See also Disease
American Board of: See American Board
Armed Forces Institute of, new building (photo), 504
forensic, Subcommittee on, (Committee report) 837
medicolegal, fellowship in, Md., 1455
presuppose physicians' knowledge of, in medical writing, [Torelvia] 1380—C
PATIENTS: See also Disease; Medical Service; Surgery; under names of specific diseases
Chronically Ill: See Disease, chronic
Committee to Hear Complaints from: See Societies, Medical
Communication with Physician: See Privileged Communications
Fees Charged to: See Fees
Hospital: See Hospitals
"Information for Patients," booklet from Presbyterian Hospital, Philadelphia, 647—E
physician relationship in industry, [Hughes] *1410
physician relationship under NHS, England, 1195
private beds in medical teaching, [Armstrong] *82; 149—E
reception of; daughter of physician, 664—C
Rehabilitation: See Rehabilitation
"To All My Patients" A.M.A. office plaque, 152
Transport of: See Ambulances
what Philadelphia physicians tell those with cancer, [Fitts & Bavdin] *901; [Bowen] 1370—C
PAVERIL: See Dioxyline
PAY: See Wages
for Physicians Services: See Fees
PEAS
Matchless Brand Dietetic Pack, 645
Overland Brand Dietetic Pack, 1099
PECTUS Excavatus: See Thorax, funnel chest
PEDIATRICIANS
role in preventing needless neonatal deaths, [Clifford] *473
PEDIATRICS: See also Children; Infants
American Board of: See American Board
International Congress of (7th), 41
neurology fellowship available from Levinson Foundation, 1027
research benefit, Chicago, 568
residency fellowships by American Academy of Pediatrics, 1371
society to be formed, Kans., 37
PELLAGRA
Kashiorkor differentiated from, (Council article), [Williams] *1284
PEMBERTON Lecture: See Lectures
PEMPHIGUS
familial benign chronic, [Hailey] 1213—ab
PENETROMETER
Braun, to control consistency of contraceptives, (Council article), [Gamble] *1021
PENICILLIN
G: See Penicillin treatment
O: See Penicillin treatment
pharmacology of, Sir Alexander Fleming discusses in Shattuck lecture, 94—ab
procaine, in treatment of early syphilis, [Thomas] 678—ab
products, stability for aqueous injection, [Buckwalter] 679—ab
toxicity, fatal anaphylactic shock, [Pick] 1406—ab
toxicity, penicillin-sensitive patient, use of chlorprophenpyridamine, [Beck] *1170
toxicity, reactions not prevented by adding antihistamine, 258; (replies) [Rapaport & others; Luippold; Simon; Roberts] 1498
treatment combined with chlorprophenpyridamine maleate, in endocarditis, [Beck] *1170
treatment combined with 5 drugs in rheumatic disease, [Ballabio] 1491—ab
treatment, fatal staphylococcus enteritis after, [Fairlie & Kendall] *90
treatment, intermittent massive, in surgery, [von Lutzki] 1226—ab
treatment of endocarditis, with penicillin O, [Geraci] 173—ab
treatment of epidemic cerebrospinal meningitis, [Izar] 1591—ab
treatment of neurosyphilis with penicillin G, [Dammann] 1322—ab
treatment plus dihydrostreptomycin in bacterial endocarditis, [Geraci] 1577—ab
treatment plus streptomycin in urology, [Strähuber] 1489—ab
treatment plus sulfadiazine or alone in pneumonia, [Erasmus] 1593—ab
treatment plus sulfonamides as prophylactic in rheumatic fever, [Roberts] 448—ab
treatment, preventive, of streptococci infections and carrier states, [Wannamaker] 593—ab
treatment, preventive, of streptococcic infections, Denmark, 1112
treatment, serum levels after, [Huang] 244—ab
treatment, short term combined in endocarditis, [Geraci] 1577—ab
treatment, to control surgical infections, [Meleney & Johnson] *1253
treatment vs. arsphenamine and bismuth in neurosyphilis, [Verjaal] 1224—ab
treatment vs. malaria in neurosyphilis, [Thomas] *721
PENIS: See also Circumcision
erythroplasia of Queyrat, [Merricks] 172—ab; [Friedman] 173—ab
plastic induration: Peyronie's disease, 990
PENNSYLVANIA: See Philadelphia
University of: See University
PENSIONS: See Retirement
PENTAERYTHRITOL TETRANITRATE (Peritrate tetranitrate; penthrite)
coronary vasodilators evaluated, [Russek & others] *207
N.N.R., (Chemo Puro) 727
PENTHRITE: See Pentaerythritol Tetranitrate
PENTYLENETETRAZOLE (Metrazol)
treatment in aged, [Levy] *1260
PEORIA Plan for Human Rehabilitation, 1025
PEPTIC ULCER
complications: liver cirrhosis, [Antonini] 1218—ab
diagnosis (gastroscopic) of gastric ulcer, [Schindler] 1313—ab
etiology: nervous factors, [Robinson] 257—ab
gastric decompensation, [Gibb] 1316—ab
gastric, problem, study 1000 cases, [Smith & others] *1505
giant benign gastric ulcers, [Marshak] 1313—ab
hemorrhage, [Saltzstein] 676—ab
hemorrhage from gastric and duodenal ulcer, [Parenteau] 1215—ab
in women, [Clark] 251—ab
multiple Curling's ulcer, [Bothe] 1054—ab
pain in, [Kinsella] 1222—ab
PEPTIC ULCER—Continued
perforation during cortisone treatment of arthritis, [Kerdasha] 1053—ab
perforation in newborn, surgery for, [Lichtenstein & others] *557
perforation, oxytetracycline in, [Schultz] 1489—ab
perforation, roentgen diagnosis of pneumoperitoneum [Gaines] 242—ab
perforation, treatment, Brazil, 1564
postoperative jejunal ulcer, Brazil, 745
problem, [Wangensteen] 1317—ab
surgical treatment, Norway, 163
surgical treatment of duodenal ulcers of posterior wall, Brazil, 969
surgical treatment of gastric ulcer, [Smith & others] *1505
surgical treatment, radical gastrectomy, [Boyden] 763—ab
surgical treatment, segmental gastric resection, [MacLean] 762—ab
surgical treatment, vagotomy, clinical observations, [Mandl] 596—ab
surgical treatment, vagotomy vs. gastric resection; ulcer recurs after resection or gastroenterostomy, [Walters & Chance] *993
treatment: See also Peptic Ulcer perforation
treatment, anticholinergic drugs, [Ruffin & others] *1159
treatment, conservative, late results, [Banks] 450—ab
treatment, licorice juice, [Carpetti] 1219—ab
treatment, occupational therapy, [Ehrlich] 881—ab
PERCY (Nelson M.) Prize: See Prizes
PERFORATION: See Appendicitis; Intestines, diverticulum; Lymphatic System; Peptic Ulcer
PERIARTERITIS
nodosa, [Fahrländer] 985—ab
nodosa, neurological symptoms; treatment, [Canestrini] 1490—ab
PERICARDITIS
tuberculous, streptomycin cures; tuberculous meningitis later, [Aceot] 887—ab
PERICARDIUM
constrictive, pathogenesis, [Moschcowitz] *194
effusions (malignant), radioactive gold for, [Seaman & others] *630
PERIODIC
Paralysis: See Paralysis
Physical Examination: See Physical Examination
PERIODICALS: See Journals
PERIODICITY: See also Paralysis, periodic
cyclic neutropenia (at 21-day intervals), splenectomy for, [Coventry] *28
PERIPACHYMENINGITIS
spinal, epidural space in, [Antoni] 689—ab
PERITONEOSCOPY
cholangiography, 856—E
PERITONEUM: See also Pneumoperitoneum
adhesions, cortisone prevents, [Lyall] 525—ab
effusions (malignant), radioactive gold for, [Seaman & others] *630
factor in sterility, [Murray] 1577—ab
Inflammation: See Peritonitis
Irrigation (artificial kidney): See Kidneys, artificial
PERITONITIS
treatment, oxytetracycline, [Schultz] 1489—ab
PERITRATE Tetranitrate: See Peniaerythritol Tetranitrate
PERMANGANATE: See Potassium permanganate
PERNICIOUS ANEMIA: See Anemia, Pernicious
PERSIMMONS
diospyrobezoar, [O'Leary] 587—ab
PERSONALITY: See also Behavior; Psychosomatic Medicine
changes in children induced by antihistamines, [Schaffer] 589—ab
psychic factors in myocardium infarction, [van Balen] 1489—ab
PERSPIRATION: See Sweat
PERTUSSIS: See Whooping Cough
PERUVIAN BALSAM
paste with dried plasma for decubitus ulcers, [Clark & Rusk] *787
PESSARIES
intracervical and intrauterine devices, (Council report) 1285
PETHIDINE: See Meperidine
PETIT MAL: See Epilepsy
PETRAGNANUS Anatuberculin: See Tuberculosis, immunization
PEYRONIE'S Disease: See Penis, plastic induration
PFEIFFER Research Foundation: See Foundations
PHARMACISTS
Institute, Wis., 651
PHARMACOLOGY: See also Drugs; Pharmaceuticals; Pharmacists
German Institute for (200th), 41
International Council of Pharmacologists, 497
treatment of aged in state mental hospital, [Levy] *1260
PHARMACOPEIA
British (1953), changes in, 1378
U. S.: See "U. S. Pharmacopeia" under Medicolegal Abstracts at end of letter M

PHARMACY
A.M.A. Council on: See American Medical Association
Practice Acts: See Medicolegal Abstracts at end of letter M
PHARYNGITIS
ulcerative, in infant after immunization injection, 1230
PHARYNX
surgery, instrument for endotracheal anesthesia during, [Barton] *1017; (correction) 1360
PHEMEROL CHLORIDE: See Benzethonium Chloride
PHENINDIONE
N. N. R., (Gane) 1363
vs. bishydroxycoumarin as anticoagulant, Norway, 876
PHENOL
aqueous, paravertebral block with, [Haxton] 167—ab
PHENOLSULFONPHTHALEIN
renal function test, [Goldring] *1247
PHENYLBUTAZONE (Butazolidin; Butapyrin; Irgapyrin)
toxic effects, [Nassim] 524—ab
toxicity: agranulocytosis, [Kiely] 594—ab
toxicity: exfoliative dermatitis, [Fishman & Reynolds] *642
treatment (combined) in rheumatic disease, [Ballabio] 1491—ab
PHEOCHROMOCYTOMA
bilateral familial, successful removal, in siblings, [Roth] 676—ab
hypertension and, [Hartl] 770—ab
in 9-year-old Negro boy, [Goldfarb] 1311—ab
PHI Delta Epsilon Lecture: See Lectures
PHILADELPHIA
physicians, what they tell their patients with cancer, [Fitts & Ravdin] *901; [Bowen] 1570—C
PHILATELY: See Postage Stamps
PHILIPS Lecture: See Lectures
PHLEBITIS: See also Thrombophlebitis
sclerotherapy for varicose veins contraindicated in? 1141
PHLEBOTHROMBOSIS: See Thrombophlebitis
PHLEGMASIA CERULEA DOLENS
after injecting sodium morrhuate, [Nelson] 977—ab
PHOSPHORUS
metabolism in paraplegia, [O'Connell & Gardner] *709
radioactive, polycythemia vera, 1415
treatment combined with vitamin B_{12}, [Ronconi] 599—ab
PHOTOGRAPHY: See also Moving Pictures
medical, class in, Calif., 568
PHTHALYLSULFACETAMIDE
intestinal antiseptics, [Poth] *1516
treatment of surgical infections, [Meleney & Johnson] *1256
PHTHALYLSULFATHIAZOLE (sulfathalidine)
intestinal antiseptic; also combined with neomycin, [Poth] *1516
PHYSICAL DEFECTS: See Blindness; Crippled; Handicapped; Rehabilitation
PHYSICAL EDUCATION: See Athletics
PHYSICAL EXAMINATION
of students, Belgium, 1111
periodic health examinations, 1449—E
PHYSICAL EXERCISE: See Exercise
"PHYSICAL LABORATORY": See American Medical Association
PHYSICAL MEDICINE: See also Ultrasonics
American Board of: See American Board
A.M.A. Council on: See American Medical Association
course on, Kansas, 735
seminar on, Pa., 571
PHYSICAL REHABILITATION: See Rehabilitation
PHYSICAL STRESS: See Stress
PHYSICAL THERAPY: See also Diathermy; Cold, therapeutic use; Physical Medicine; Radium; Roentgen Therapy; Ultrasonics; Ultraviolet Rays
A.M.A. Council on: See American Medical Association Council on Physical Medicine and Rehabilitation
course in, New York, 1104
Man in the Window (film review), 1117
mobile unit, Pa., 866
relation of physician and physical therapist, 920—ab
PHYSICALLY HANDICAPPED: See Handicapped
PHYSICIANS: See also Economics, Medical; Medical Jurisprudence; Medical Service; Medicine, profession of; Surgeons
Allen: See Physicians, foreign
American, Serving Overseas: See Korean War, Heroes
amplifying stethoscopes for physician who has had hearing loss, 776
attitudes toward voluntary health insurance, survey, 1286—E
avocations, cooking for pleasure, [Leisure Corner] *975
avocations, flowering hobby, [Leisure Corner] *553
PHYSICIANS—Continued
avocations, model railroading, father-and-son hobby, [Leisure Corner] *1310
avocations, Physicians' Art and Hobby Show, Minn., 37
avocations, physicians' orchestra, Calif., 568
avocations, physicians' orchestra, Philharmonic Society, Chicago, 1103
avocations, "Sunday" painter, [Leisure Corner] *508
Awards to: See Prizes
Bills: See Fees
continuation courses for, *135; (to July 1954) 1365—E; *1381
Courses for: See Education, Medical, graduate
Deaths: See also list of Deaths at end of letter D
deaths of distinguished vs. nondistinguished doctors, [Poynton] 1379—C
definition of, Belgium, 660
Directory of: See British Medical Register
Draft Legislation regarding: See Medical Preparedness
Education of: See Education, Medical
Emergency Calls: See Emergency
Ethics: See Ethics, Medical
expedition to South America: want to recruit a young graduate, [Acworth] 235—C
Federal Income Tax: See Tax
Fees: See Fees
Fellowships for: See Fellowships
foreign, join state university staff, New York, 650
Graduate Work: See Education, Medical
Heroic Action: See Korean War: Heroes
Hospital Relationship: See Hospitals
in Service: See Armed Forces; Army, U. S.; Navy, U. S.
Income Tax: See Tax
Industrial: See Industrial Health
Killed in Service: See Korean War, Heroes
Kriz (Dr. R. E.) presents pool to home town, Neb., 736
League Against Epilepsy, 608
leaving active military service, survey of, (Council report) 841
Lectures honoring: See Lectures
Licensure of: See Licensure
look at Old-Age and Survivors Insurance, [Blasingame & Dickinson] *921; 959—E
Malpractice by: See Malpractice
Medals for: See Prizes
Medical Examiner: See Medical Examiner
Medical Responsibility: See Malpractice; Medical Jurisprudence; Medicolegal Abstracts at end of letter M
Memorial: See also Fellowships; Lectures; Prizes
memorial, carillon to Dr. W. F. Cogswell, Montana, 1369
memorial, "Carl Mitchell," Mich., 154
memorial, Cofer Memorial Chapel, N. Y., 737
memorial, Craig-Brown, 1370
memorial, Manning public health scholarship, Neb., 1103
memorial, Mountin Volume, 1371
memorial, plaque dedicated to those serving in the Indian Wars, Ohio, 436
memorial to Dr. Pennell, Pa., 155
memorial to Richard Strong, Philippine gift as, 569
memorial, Watts chair of surgery, bequest for Va., 651
Military Service: See Armed Forces; Medical Preparedness
Mobilization: See Medical Preparedness
National Conference on Physicians and Schools, 151; 853; 858
Negligence of: See Malpractice
office laboratory, N. Y., 1184
office management, (Business Practice) *1045
office, public relations in, A. M. A. plaque, 152
office records, analyzed, London, 1469
office, standard for, report by B. M. A., London, 1302
office use of frog test for pregnancy, [Hodgson] *271
opportunities and responsibilities in world affairs, [Trimble] *1143
paging system (new), (Detroit) 37; (Wis.) 1291
Partnerships: See Partnerships
patient's reception by; daughter of physician, 664—C
placement activities (state), 1522—E
placement assistance for those released from military service, (Council report) 841
placement, in Illinois, (Council report) *671
placement, in Texas, (Council article) *1473
placement, rating communities from physician's standpoint, (Council report) 236
placement service, (Council report) 948
placement service, second regional conference, (Council report) *1116
portrayal, in television and radio advertising, A.M.A. resolutions on, 829
positions open, Chicago Board of Health, 1026
PHYSICIANS—Continued
positions open in VA, Tex., 504
positions open, mental health director wanted, Pa., 222
positions open, otolaryngologist wanted in India, 439
Postgraduate Education: See Education, Medical
Practicing: See also Medicine, practice; Physicians, supply
practicing, A.M.A. General Practitioner's Award to Dr. Greenwell, 1366—E; 1526
practicing, family physician and heart disease, iatrogenic aspects, [Mills] *910
practicing, family physician and public health department, [Getting] *265
practicing, general practitioner reaction to NHS, England, 1195
practicing, general practitioners and cancer propaganda, London, 234
practicing, general practitioners scientific session, 1454
practicing, industrial medical service by private practitioners, [Ricke] *198; [Hughes] *1438
practicing, Lease on Life (film review), 878
practicing, questionnaire by British Empire Cancer Campaign, 1377
practicing, refresher course for general practitioners, 573
practicing, "Research Newsletter No. 1" of College of General Practitioners, London, 1039
practicing, 'Survey of General Practitioner Schemes in British Medical Schools," 445
practicing, U. of Glasgow graduates after 25 years, 972
presuppose knowledge of histology and pathology in medical writing, [Torcivia] 1380—C
Prescriptions: See Prescriptions
Privileged Communications: See Privileged Communications
Prizes for: See Prizes
public forums, Iowa, 1556
reading habits of, England, 1196
Resident: See Residents and Residencies
Retirement: See Retirement
role in preventing musculoskeletal deformity after poliomyelitis, [Bennett] *79
Services: See Medical Service
Spanish Association of, organized contest for writers and artists, 748
Specializing: See Specialties
Statements: See Fees
supply, distribution by medical service areas, Bulletin 94 of A.M.A. Bureau, 844
supply, distribution in Texas, (Council article) *1474
supply in India, [Bowers] *1169
supply in Israel, 745
supply, number listed in British Medical Register, 1378
Training: See Education, Medical
veteran, appreciation day honoring Dr. Woods, Texas, 1458
veteran, Dr. Bierring, aged 84, retires as health commissioner, Ia., 36
veteran, Dr. Clarence T. Coleman Day, Ky., 1454
veteran, Dr. Dailey Day, Wis., 497
veteran, Dr. Melby Knight, Minn., 222
veteran, Dr. Vadhelm Appreciation Day, Minn., 736
veteran, Dr. Whetstone Day in Sylacauga, Ala., 36
veteran, 50 year awards, Ga., 1102
veteran, 50 year buttons, Wash., 738
veteran, 50 year club, (Miss.) 436; (S. D.) 1105; (Okla.) 1370; (Vt.) 1371; (Tenn.) 1558
veteran, 50 year plaques, Pa., 155
Wages for: See Wages
Waiting Rooms: See Physicians, office
what Philadelphia physicians tell patients with cancer, [Fitts & Ravdin] *901; [Bowen] 1570—C
who visit Greece, appointments for, [Mangun] 973—C
Women: See also Students, Medical, women
women, Dr. Sabin not first woman graduate of Johns Hopkins but Dr. Packard, (correction) 1559
women, in U. S., *126
working for advanced degrees in medical schools, 1952-1953, *122; *123
"Your Doctor" film, (report) 831
PHYSICS
Nuclear: See Atomic Energy; Radioactive Isotopes
PHYSIOLOGY
International Union of Physiological Sciences, 571
PHYSIOTHERAPY: See Physical Therapy
PHYSIQUE: See Constitution
PHYTOREZOAR
from eating wild dates, Turkey, 1471
PICROTOXIN
treatment of barbituric acid poisoning, [Mousel] *459
PICTURES: See Art; Moving Pictures; Physicians, avocations; Photography; Portraits (cross reference); Television

PIGMENTATION: See Chromoblastomycosis; Color; Stains and Staining
of Skin: See Skin
PILOT'S METHOD
for staining eosinophils, 1067
PIMPLES: See Acne
PINTA
in Mexico, identified, [Edmundson] 58—ab
in Mexico: mass survey, [Edmundson] 58—ab
PIPERPHENIDOL HYDROCHLORIDE (Reitine)
name accepted by Council, 801
PITCHER (baseball)
elbow in, 74
PITUITARY
Adrenocorticotropic Hormone: See Corticotropin
aspects of infertility in men, [Bishop] *534
Cushing's Syndrome: See Cushing's Syndrome
diencephalohypophysial dysregulation cause of obesity, 1127—ab
electrocoagulation of in Cushing's syndrome, [Arner] 1123—ab
extract use in prolonged labor, [McCain & others] *695
hormone metabolism in paraplegia, [O'Connell & Gardner] *709
hormones, synthesis by Du Vigneaud and his associates, 1524—E
insufficiency, role in azoospermia, (reply), [Welsman] 694
necrosis in pregnancy, [McKay] 1206—ab
necrosis (postpartum), Brazil, 1376
roentgen irradiation in diabetes mellitus, [Pais] 1586—ab
surgery, hypophysectomy in man, [Luft] 171—ab; [Detric] 1590—ab
tumors, malignant, [Mosovich] 1588—ab
PLACEBO
administered to aged, changes after, [Levy] *1260
effect on attacks of pain, [Voyles & others] *12
ergometric studies on intermittent claudication, [Simon & Wright] *98; [Colleus] 1115—C; (reply) [Simon & Wright] 1115—C
PLACEMENT: See Physicians
PLACENTA: See also Amniotic Fluid; Fetus
transmission of Western equine encephalomyelitis, [Shinefield] 591—ab
tumor: hydatidiform mole (benign chorioangioma), [Snoeck] 982—ab
PLAGUE
infection, Calif., 435
vectors, study of, Calif., 1454
PLANES: See Aviation
PLANNED Parenthood: See Contraception
PLANTS: See Flowers; Garden; Ragweed
flowering hobby, [Leisure Corner] *55
PLASMA: See also under various subheads of Blood
Antihemophilic: See Antihemophilic Plasma
Expander: See Dextran
paste of dried plasma and Peruvian balsam for decubitus ulcers, [Clark & Rusk] *787
preserve living bone in, [Tucker] 66—ab
Transfusion: See Blood Transfusion
PLASMOCYTOMA
of lung with hypertrophic osteopathia, [Plenk] 770—ab
PLASTER
Cast: See Cast
PLASTIC
dressings for burns and operative wounds, Sweden, 1569
reagent bottles for alkalis, [Cornbleet] 1571—C
PLASTIC SURGERY: See Surgery
PLATELETS: See Blood platelets; Purpura, thrombopenic
PLAVOLEX: See Dextran
PLEURA
effusion, *p*-aminosallcylic acid and dihydrostreptomycin effect on frequency, [Birath] 1210—ab
effusion (malignant), radioactive gold treatment, [Seaman & others] *630
PLEURISY
Purulent: See Empyema
serofibrinous, effect of pyrazol derivatives, [Pestel] 689—ab
PLEURODYNIA, EPIDEMIC
Coxsackie virus infection and, [Patz] 601—ab
Coxsackie virus isolated from 2 patients, [Swain] 597—ab
outbreak in North Texas, [Risser] 249—ab
Oxford epidemic [Warin] 597—ab
PLEXUS: See Brachial Plexus
PLUMBISM: See Lead
PNEUMATOCELE
[Mayer & Rappaport] *700
PNEUMOCELE: See Pneumatocele
PNEUMOCONIOSIS: See Pneumonoconiosis
PNEUMOLYSIS: See Lungs surgery
PNEUMONIA: See also Bronchopneumonia
atypical primary, bronchogenic cancer simulates, [Custer] 1318—ab
chest pain from exposure to soil dust in farmers, [Williamson] 164—C
treatment, penicillin and sulfadiazine, [Erasmus] 1593—ab
Virus: See Pneumonia, atypical primary
PNEUMONOCONIOSIS
anthracosilicosis, Belgium, 660
silicosis and, 1327
PNEUMONOGRAPHY: See Adrenals, cortex
PNEUMONOLYSIS: See Lungs, surgery
PNEUMOPERITONEUM
artificial, complications, [Robrowitz] 590—ab
artificial, diagnostic, in sex-endocrine disturbances, [Kunstadter] 1203—ab
artificial, treatment of emphysema, [Brackenridge] 67—ab
artificial, treatment of pulmonary tuberculosis, Turkey, 972
artificial, vs. pneumothorax; incidence of empyema, [Heaton] 1486—ab
roentgen diagnosis of, in perforated peptic ulcer, [Gaines] 242—ab
PNEUMOTHORAX
positive pressure, emergencies in newborn, [Cooper & others] *1077
spontaneous, pathology; treatment of various forms [Blancalana] 253—ab
PNEUMOTHORAX, ARTIFICIAL: See also Tuberculosis of Lung
effect of *p*-aminosalicylic acid and dihydrostreptomycin on, [Birath] 1210—ab
vs. pneumoperitoneum; incidence of empyema, [Heaton] 1486—ab
POETRY: See Book Reviews at end of letter B
POISONING: See also under names of specific substances as Anticholinesterase; Arsenic; Barbiturates; Lead
Industrial: See Industrial Dermatoses; Industrial Diseases
perspective vs. caprice in evaluating toxicity of chemicals, [Seevers] *1329
U. of Illinois toxicology service, 1025
POLIOENCEPHALITIS
treatment, massive doses of vitamin B_{12} [Lereboullet] 601—ab
POLIOMYELITIS
acute anterior, hepatolienal symptoms, [Kalk] 1218—ab
bulbar, acrosol trypsin in, [Varga] 1203—ab
bulbar; laboratory guides used at Memorial Hospital, Sheridan County, Wyo., [Varga] 50—C
bulbar, relation to previous tonsillectomy, [Southcott] 1587—ab
complement fixation test, [LeBouvier] 1057—ab
complications: cardiac affections [Georg] 770—ab
complications: myocarditis [Teloh] 56—ab
Coxsackie viruses in, [Stanley] 251—ab
epidemic in Copenhagen in 1950, [Bjerglund] 770—ab
epidemic, in Essen, [Hartmann] 1058—ab
experimental in mice, effect of fatigue, [Rosenbaum] 1484—ab
immunization (passive), [Siegel] 884—ab
immunization preceding, [Geffen] 687—ab
in Canadian Eskimos, [Wood] 598—ab
in infants under 6 months, [Geffen] 1217—ab
incidence, London, 583
incidence, U. S. 40; 157; 224; 438; 499; 573; 652; 739; 807
musculoskeletal deformity after, role of physician in preventing, [Bennett] *79
National Foundation for Infantile Paralysis, (fellowships) 438
not reactivated 3 years later, by tonsillectomy, 456
paralysis (respiratory) in, physical therapy, [Huddleston] 1208—ab
postinoculation, London, 506
preventive measures, Denmark, 445
spinal anesthesia relation to, 527
tonsillectomy vs., 456; [Southcott] 1587—ab
tonsils and adenoids in relation to, [Hayes] 1481—ab
treatment center, Belgium 1111
treatment, Emerson Rocking Bed, Standard Hospital Model, 33
treatment, gamma globulin [Lamarca] 767—ab
treatment, gamma globulin, limitations, [Hammon] 752—ab
treatment in hospital, London, 748
treatment, induced sleep [Brenner] 1060—ab
treatment, tracheotomy, [Davis & others] *1156
POLLEN: See Ragweed
POLLINOSIS: See Hay Fever
POLYCYTHEMIA
sequels: leuko-erythroblastosis and myelosclerosis, [Beattie] 1217—ab
vera: cause; treatment; effect of high altitude, 1415
POLYETHYLENE
catheter, simple coupling device for, [Alman & Whoriskey] *562
POLYMYXIN B SULFATE (Aerosporin)
treatment of surgical infections, [Meleney & Johnson] *1256
POLYNEURITIS: See Neuritis
POLYPS
of colon and rectum, detection program, [Gianturco & Miller] *1429
of stomach, 455
POLYRADICULITIS: See Guillian-Barré Syndrome
POLYSEROSITIS: See Serositis
POLYVINYL
sponge for bolstering bosoms; surgical activities of Dr. R. A. Franklyn, 1200—BI
POLYVINYLPYRROLIDONE (Kollidon)
treatment of burn shock, [Cordice] 522—ab
treatment of hemorrhagic and traumatic shock, [Cordice] 1214—ab
POOL: See Swimming pool
POOR: See Medically Indigent
POPULATION: See Vital Statistics
PORADENITIS: Lymphogranuloma, Venereal
PORK: See Trichinosis
PORPHYRIA
blood picture in, [Trainito] 1589—ab
in lead exposure, [Shiels] 1488—ab
in surgery, [Kergin] 1486—ab
PORTAL VEIN
blood pressure, catheterization of hepatic vein to estimate, [Krook] 1591—ab
hypertension, blood picture after operation for, [Macpherson] 252—ab
hypertension, duodenum-lung circulation time in, 1376
hypertension in esophageal varices, [Thorek] *704
hypertension, ligate hepatic artery for, [Popper & others] *1095
hypertension, portacaval anastomosis for, [Ripstein] 1403—ab
hypertension, shunt operation for decompression, [Jahnke] 1581—ab
obstruction, [Marion] 1592—ab
portacaval shunt for bleeding esophageal varices, 1286—E
venography via portal and splenic routes, [Rousselot] 1403—ab
PORTRAITS: See under names of individuals as Faust; Greenwell
of Men Killed in Action: See Korean War, Heroes, for specific names
POSITIONS Open: See Physicians positions open
POSTAGE STAMPS:
medical, annual exhibit at U. of Illinois, 1289
POSTGRADUATE Work: See Education, Medical
POSTMORTEM: See Autopsies
POSTNATAL: See Infants, Newborn
POSTOPERATIVE: See Surgery
POSTPARTUM: See Puerperium
POTASSIUM
arsenite solution treatment of psoriatic arthritis, 1230
deficit, effect on amino acid utilization, [Frost] 174—ab
deficit from persistent vomiting during pregnancy, [Lans & others] *1012
deficit, symptoms, 184—ab
in Blood: See Blood
intoxication, pain from, in Kimmelstiel-Wilson syndrome; insulin and glucose controls, [James & others] *545
metabolism in paraplegia, [O'Connell & Gardner] *708
permanganate as abortifacient, London, 1301
permanganate, removal of stains from glass urethral syringes, 258; (replies; use oxalic acid) [Paimer; Evans] 894
POTATOES
Beech-Nut Junior Sweet Potatoes 1099
POTT'S Disease: See Spine, tuberculosis
POVERTY: See Medically Indigent
POWER, Atomic: See Atomic Energy
PRACTICE of Medicine: See Medicine, practice
PRACTITIONERS: See Physicians
Illegal: See Quackery
PRE-CEPTORSHIPS: See also Interns and Internships
at U. of Texas, (Council article) *1475
programs, *130
PREFRONTAL Lobotomy: See Brain surgery
PREGNANCY: See also Fertility; Fetus; Impregnation; Labor; Maternity; Obstetrics; Placenta; Puerperium
advisable in nephritis?
antihistamines effect on coagulation time, 1229
bishydroxycoumarin therapy in, effect on fetus and newborn, 1142
complications: breast cancer, [Check] 56—ab
complications: cerebral palsy, 1484
complications: diabetes mellitus, management [Toistoi & others] *998
complications: fatal, [McKay] 1206—ab
complications: hypertension (severe essential), protoveratrine controls, [Meilman] *543
complications: malignancies, irradiation treatment, [Kaplan] 64—ab
complications: megaloblastic anemia, [Piozzi] 1224—ab
complications: myasthenia gravis, [Fraser] 1.22—ab
complications: pneumoperitoneum in pulmonary tuberculosis, Turkey, 972
complications: rubella, aslocate gamma globulin to prevent, 74
complications: rubella: pathologic effect on chord, [Tedeschi] 1483—ab
complications: rubellar embryopathy, [Malbran] 886—ab
complications: subacute bacterial endocarditis, [Tedowitz] 753—ab
complications: tests for syphilis in pregnant women, Norway, 875
cramps of leg during, 992; 1229
diagnosis, advantages of X-ray, [Barter] 248—ab

153
953

PREGNANCY—Continued
diagnosis, false positive Friedman or Aschheim Zondek tests? 1229
diagnosis, office use of frog test, [Hodgson] *271
diagnosis, Schlör iodine boiling test, [Benthin] 1582—ab
diagnosis, toad test, [de Marchi] 176—ab
diagnosis, was patient pregnant? 607
erythroblastosis prevention, 1232
hemophilia-like disease after, [Frick] 517—ab
hirsutism during, 1497
influence on nutritional processes, [Spies] *185
Interruption of: See Abortion
Multiple: See Twins
Protection from: See Contraception
roentgen rays during, 218—E
Syphilis in: See Pregnancy, complications
Toxemia of: See also Eclampsia; Pregnancy, vomiting in
toxemia of, protoveratrine for, [Meilman] *540
vitamin A (excessive) and congenital abnormalities, 1176—E
vomiting in: allergic factor; treated with antazoline and desoxycorticosterone [Youssef] 600—ab
vomiting in, compound 2601—A for, [Friend & Cummins] *480
vomiting (persistent) in, hypokalemia due to, [Lans & others] *1012
PREMATURE Infants: See Infants, premature
PREMEDICAL Work: See Education, Medical
PRENATAL: See Fetus; Pregnancy
PREPAREDNESS, Medical: See Medical Preparedness
PREPAYMENT Plans: See Hospitals, expense insurance
PREPUCE: See Circumcision
PRESCRIPTIONS
for private patients, London, 446
PRESIDENT'S COMMISSION ON HEALTH NEEDS OF THE NATION
Bureau report discusses, 844
PRESIDENT'S REORGANIZATION PLAN: See Reorganization Plan
PRESS: See Journals; Newspapers
PREVENTIVE MEDICINE: See also Immunization; Vaccination
American Board of: See American Board
division in U. S. Air Force, Col. Bedwell new chief, 1466
preventoriums for school children, Paris, 664
program at U. of Louisville, gift from Kellogg Foundation, 435
PREVENTORIUMS: See Stomach cardiospasm
PRIMIDONE (Mysoline)
name accepted by Council, 801
PRIODAX: See Acid, iodoalphionic
PRISCOLINE: See Tolazoline Hydrochloride
PRIVATE PRACTICE: See Medicine, practice
PRIVILEGED COMMUNICATIONS
psychiatric, (Committee report) 931
PRIVINE: See Naphazoline Hydrochloride
PRIZE FIGHTING: See Boxing
PRIZES: See also Fellowships; Lectures; Scholarships
American Association of Obstetricians, Gynecologists and Abdominal Surgeons, Foundation Prize, 1459
American Diabetes Association, 651
American Goiter Association's Merit Award, 1187
American Institute of Graphic Arts to *Today's Health*, 1267
A.M.A. General Practitioner's Award to Dr. Greenwell, 1366—E; 1526
American Society for Study of Sterility, 497
American Society of Plastic and Reconstructive Surgeons citation, 1454
Blum (Theodor), 1457
Borden, 1292
Burdick (Ward) Award 968
Burke (William), 1460
Commercial Solvents Award in Antibiotics, 156
Cross of Knight of the Legion of Honor, 435
Distinguished Citizen citation to Dr. Ellis, Ark., 1454
Faculté de Médecine de Paris, for medico-surgical films, 1293
Friedenwald (Julius) Medal, 650
Goldberger Award, (in 1952) 939; (in 1953 to Dr. McLester) 1367
Howe (William) Award, 1368
Ill (Edward J.) Award, 736
Imperial Prize of Japan Academy for 1953, to Dr. Yoshida for study of sarcoma, 47
Kimbie Glass Methodology Research, 1459
Mississippi Valley Medical Society, 1559
Norman (Hubert), 1559
Osborne and Mendel Award, 1187
Paul-Lewis Laboratories award to enzyme chemist, 872
Percy (Nelson M.), 495
residents and interns award, N. J., 436
Scroll of Merit, pathologist's award to Dr. Larson, 1024
Seaman (Louis Livingston), 1194
Sedwick Memorial Award, 1371
Società Italiana de Reumatologia, 1187
PRIZES—Continued
Soler (Blanco) prize, Spain, 748
Van Meter, 1188
Variety Club-Will Rogers Hospital tuberculosis achievement awards, 1105
deVilliers, (Robert Roesler) Award, 1290
Wellcome Award, 1194
PROCAINE AMIDE HYDROCHLORIDE (Pronestyl)
effect on cardiac arrhythmias, [Boyadjian] 1126—ab
PROCAINE HYDROCHLORIDE
Penicillin: See Penicillin
prefrontal injection in obsessive-compulsion reaction, [Myers & others] *1015
PROCONVERTIN
prothrombin control (Owren's method), [Lund] 602—ab; 662; 876
PROCTOLOGY: See also Rectum
American Borad of: See American Board
PROCTOR Lecture: See Lectures
PROFESSIONAL SECRECY: See Privileged Communications
PROFESSIONS: See Dentistry; Medicine; Nurses and Nursing
PROGESTERONE
U.S.P., N.N.R. [Gold Leaf] 727
PROGNOSIS: See also under names of specific diseases
principles and practice of, (Billings Lecture) [White] *75
PROLAPSE: See Rectum; Spine, intervertebral disk
PROMETHAZINE
disulfiram combined with, [Martensen-Larsen] 1184—ab
PRONESTYL: See Procaine Amide Hydrochloride
PROPYL ALCOHOL: See Isopropyl Alcohol
PROSTATE
biopsy, transrectal, [Grabstald & Elliott] *563
cancer, bilateral total adrenalectomy in, [Blunden] 1319—ab
cancer, changes in after adrenalectomy, [Franks] 1216—ab
cancer, combined orchiectomy and estrogen for, [Holder] 885—ab
cancer, desiccated thyroid or thyroxin and estrogens for, [Borrmann] 1059—ab
cancer, estrogen for, [Fergusson] 67—ab; (Tace), [Mortensen] 766—ab
cancer, estromenin for, [Francese] 599—ab
cancer (latent), autopsy study, [Edwards] 59—ab
cancer, radical retropubic prostatectomy for, [Lattimer & others] *1347
cancer, radioactive gold for, [Kerr] 240—ab
cancer, total prostatectomy in, [Colby] 172—ab
cancer, treatment, 921—ab
Inflammation: See Prostatitis
lesion cause of gross urinary hemorrhage, [Lee & Davis] *782
Surgery: See Prostatectomy
PROSTATECTOMY
combined with penicillin and streptomycin, [Strahuber] 118—ab
radical retropubic, for cancer, [Lattimer & others] *1347
total, in prostate cancer, [Colby] 172—ab
PROSTATITIS
chronic, urologic quandary, [Ghormley & others] *915
PROSTIGMINE: See Neostigmine
PROTEIN: See also Amino Acids; Meat
diet low in, cause of kwashiorkor, (Council article), [Williams] *1280
diet low in, harmful effects, [Arends] 1589—ab
in Blood: See Blood
in Urine: See Albuminuria
metabolism in paraplegia, [O'Connell & Gardner] *707
Sensitivity: See Allergy
PROTEINURIA: See Albuminuria
PROTHROMBIN: See Blood prothrombin
PROTOVERATRINE
treatment of toxemia of pregnancy, [Meilman] *540
PROTOVERATRINE A AND B MALEATES (Provell)
name accepted by Council, 1447
PROTOVERATRINES A AND B (Veralba)
name accepted by Council, 1447
PROTOZOA
Intestinal: See Intestines, parasites
PROVELL Maleate: See Protoveratrine A and B Maleates
PRUNES
Gerber's Junior, 1099
PRURITUS
treatment, hydrocortisone acetate, [Bourgeois-Cavardin] 1131—ab
PSEUDOALBUMINURIA
after cholecystography, [Holoubek & others] *1018
PSEUDOHERMAPHRODITISM: See Hermaphroditism
PSORIASIS
approach to, [Ingram] 1406—ab
arthritis; potassium arsenite (Fowler's) solution for also Goeckerman treatment, 1230
PSYCHE: See Personality; Psychiatry; Psycho—; Stress
PSYCHIATRY: See also Hospitals, psychiatric; Mental Disorders; Mental Health; Neuropsychiatry; Psycho—
American Board of: See American Board
American Psychiatric Ass'n. joint conference on mental health, 931; 1024
early development of the psychiatrist, Long Memorial Lecture, [Hall] *615
ethics of, and clinical psychology, Belgium, 660
forensic, Subcommittee on, 837
in Belgian Congo, Belgium, 873
in general practice, London, 972
lectures in Winnetka, Ill., 435; 1556
new Hadassah departments, Israel, 746
privileged communications, (Committee report) 931
residency training program, 580
services in general hospitals, [Osborn] *259
social, seminars on, Texas, 650
Thudichum Psychiatric Research Laboratory dedicated, Ill., 568
PSYCHOLOGISTS
clinical, licensure and certification, (report) 931
PSYCHOLOGY: See also Psychosomatic Medicine
clinical, ethics of, Belgium, 660
concomitants of cortisone and corticotropin therapy, [Rees] 1221—ab
Pathologic: See Psychiatry
PSYCHOPATHIC
Hospitals: See Hospitals, psychiatric
PSYCHOSES: See also Mental Disorders
due to faulty nutrition, [Spies] *190; *192
during isoniazid therapy, Paris, 48
obsessive-compulsive reaction, prefrontal procaine injection for, [Myers & others] *1015
treatment, androgens, Italy, 1468
treatment (drug) of aged in state hospital, [Levy] *1260
treatment, Induced sleep, [Delay] 1590—ab
PSYCHOSOMATIC MEDICINE
American Academy of, 866
nervous indigestion, (reply) [Reeves] 776
PSYCHOSURGERY: See Brain surgery
PSYCHOTHERAPY
of chronic ulcerative colitis, [Morrison] 1580—ab
of edema of unknown origin, (reply) [Jonas] 1068
vs. carbon dioxide inhalation in muscular rigidity, [Leavitt] 509—C
PUBERTY: See Adolescence
PUBIC BONE
Osteitis: See Osteitis, pubic
PUBLIC HEALTH: See Health, public
PUBLIC RELATIONS
A.M.A. Medical Public Relations Conference (6th), Nov. 30, 1953, St. Louis, 494; 858; (luncheon) 961; **(program) 1024**
conference, Va., 1105
Grievance or Mediation Committee: See Societies, Medical
in the doctor's office: A.M.A. office plaque, "To All My Patients," 152
manual "Rx PR", 1464
"New Ways to Better PR," new A.M.A. publication, 1367
Physicians' Public Forums, Ia., 1556
PR Doctor, (report) 831
report of Assistant to General Manager: 4 objectives, 830
serving the public, 647—E; (Dr. McCormick's address) *1529
PUBLIC SCHOOLS: See Schools
PUBLIC WELFARE
American Public Welfare Conference in Chicago, 1188
Congress of International Association for, Paris, 748
PUERPERIUM
hemorrhages from fibrinogen deficiency, [Vecchietti] 1591—ab
necrosis of anterior hypophisis, Brazil, 1376
PUERTO RICO
interservice utilization of expert military clinical consultants, [Hammond] 973—C
University of: See University
PULMONARY: See Lungs
Arteries: See Arteries
Embolism: See Embolism
Heart Disease (cor pulmonale): See Heart hypertrophy
Tuberculosis: See Tuberculosis, of Lung
PULSE
heard in ear, 990
of surgical patients with and without thromboembolism, [Peters] 1321—ab
peripheral, studies of vasospasm with glyceryl trinitrate, [Foley] 168—ab
PULMONARY VALVE
Surgical Treatment for Congenital Pulmonary Valvular Stenosis, (film review) 878
PUNCH BIOPSY: See Liver
PUNCTURE: See Heart
PUPILS (students): See Children, school; Students
PURPURA
thrombopenic, 774
thrombopenic (idiopathic), [Stefanini] 1059—ab

V 15
1953

PURPURA—Continued
thrombopenic, induced by sodium para-aminosalicylic acid, [Wurzel & Mayock] *1094
thrombopenic, intravascular hemolysis, [Monroe] 1319—ab
PYLORIC VALVE
stenosis, familial hypertrophic, [Fenwick] 764—ab
stenosis, hypertrophic, in children, [McNicholl] 525—ab
PYLORUS
spasm (infantile), methantheline in, [Levy] 245—ab
PYODERMA
treatment, erythromycin, [Freeman] 245—ab
PYRAMAL: See Pyrilamine Maleate
PYRAMIDON: See Aminopyrine
PYRAZOLE
effect on serofibrinous pleurisy and pulmonary tuberculosis, [Pestel] 689—ab
PYRENE
smoke and cancer, London, 1039
PYRIBENZAMINE: See Tripelennamine Hydrochloride
PYRIDOSTIGMINE
treatment of myasthenia gravis, [Seibert] *175
PYRIDOXINE HYDROCHLORIDE
U.S.P., N.N.R., (American Pharmaceutical) 727
β-PYRIDYL CARBINOL (Roniacol)
coronary vasodilators evaluated, [Russek & others] *207
PYRILAMINE MALEATE (Neoantergan; Pyramal)
N.N.R., (Columbus Pharmacal) 727
PYRIZIDIN: See Isoniazid

Q

Q FEVER
causal agent (Rickettsia burneti): arthropods as hosts, [Weyer] 771—ab
epidemic, [Badioli] 1588—ab
QUACKERY
cancer, exposed by A.M.A., statement by Dr. Wermer, 731
QUACKS: See Quackery; under specific names as Koch; Schirmer
QUARANTINE: See also Medicolegal Abstracts at end of letter M
for rabies, Ill., 1183
QUARTERLY CUMULATIVE INDEX MEDICUS: See American Medical Association
QUARTZ Lamp: See Ultraviolet Rays
QUESTIONNAIRE
on lay education in cancer, England, 1377
on physicians' attitudes toward voluntary health insurance, 1286—E
on postgraduate education, 1022—E
review of general practice by committee of British Medical Association, 1195
what Philadelphia physicians tell patients with cancer, [Fitts & Ravdin] *901; [Bowen] 1570—C
QUEYRAT Erythroplasia: See Erythroplasia
QUINACRINE (Atabrine; Mepacrine)
toxicity, fatal aplastic anemia, [Parmer & Sawitsky] *1172
treatment of discoid lupus erythematosus, [Miller] 1055—ab; [Parmer & Sawitsky] *1172; [Cole & others] *1515; [Farber] 1580—ab
QUINIDINE
permanent impairment of hearing been reported: 1142
treatment of chronic auricular fibrillation, [Fleischmann] 514—ab
QUININE
carbacrylic resin (Diagnex) N.N.R., (description) 1362; (Squibb) 1362
in tonic water, tinnitus from, [Yohalem] 1304—C
QUINONES
carcinogenic, from beetles, tumors in rats from, [Spies] *190

R

"Rx PR": new A.M.A. public relations manual, 434
RABIES
in bats, Pa., 1104
in man from dogs, Miss., 1184
in man from wild fox, Ga., 1102
morbidity and mortality in exposed persons, [Gremliza] 771—ab
vaccine, reactions after, [Blatt] 1574—ab
RACEMORPHAN HYDROBROMIDE (Methorphinan; Dromoran)
intoxication, nalorphine (nalline) treatment, [Domino & others] *26
RACES: See Jews; Negroes
RADAR
radiotherapy with linear accelerator a direct descendant of, London, 1301
RADIANT-heated floors, 1414
RADIATION: See also Diathermy; Radar; Radium; Roentgen Rays; Ultraviolet Rays
Ionizing: See Radioactive Isotopes
RADIATION—Continued
nephritis, [Luxton] 525—ab
protection comes of age, [Chamberlain] *488
Radiation Research, new journal, 1187
toxicity, dihydroergotamine treatment of intoxication, [Werner] 71—ab
treatment with cyclotron and linear accelerator, London, 1301
workers, low leukocyte counts in, and sick leave, [Turner] 1216—ab
RADIO: See also Television
A.M.A. resolution on portraying physicians on, 829
Frequency Energy Apparatus: See Diathermy
network, (Bureau report) 852
shows, promotion, (report) 831
transcriptions, new series: 13 programs: "Medicine Fights the Killers," 434
University of Texas Medical Branch program, 1458
RADIOACTIVE
Cobalt: See Cobalt
Gold: See Gold
Iodine: See Iodine
Isotopes: See also Atomic Energy
isotopes, catalog, 497
isotopes, course in safety, N. Y., 38
isotopes, failures and false localization in tracer technique, [Corrigan] 541—ab
isotopes, use of, 27—ab
Phosphorus: See Phosphorus
Sodium: See Sodium
Thorium: See Thorium X
RADIOIODINE: See Iodine, radioactive
RADIOLOGY: See also Radiation
American Board of: See American Board
practice in and by hospital, Ohio Attorney General opinion on, (Bureau report) 858
Radiological Society of North America, meeting in Chicago, 1292
safety, course in, N. Y., 38
services consolidated, N. Y., 436
RADIOTHERAPY: See Radiation therapy
RAGWEED
pollen, roentgenographic distribution, 1066
RAILROADS
model, father-and-son hobby, [Leisure Corner] *1310
RANDOLPH'S METHOD
for staining eosinophils, 1067
RANSON Lecture: See Lectures
RATTLESNAKES: See Snakes
RAUDIXIN: See Rauwolfia
RAUWOLFIA (Raudixin)
name accepted by Council, 1447
RAYNAUD'S DISEASE
environmental temperature for: treatment, 1141
progressive scleroderma and, [Ferrari] 596—ab
vasospasm studied with glyceryl trinitrate, [Foley] 168—ab
RAYS: See Radiation
READING
habits of physicians, England, 1195
REAGENT Bottles: See Bottles
RECORDS: See Physicians office records
RECREATION: See Leisure Corner; Physicians, avocations
RECRUITS: See Medical Preparedness
RECTUM
Administration by: See Enema
cancer, amebic granuloma stimulating, [Ernst] 1036—ab
pain, cause of: hemorrhage into hypertrophied anal papilla, [Hayes & Burr] 1115—C
prolapse, treatment, (reply), [Chitambar] 694
transrectal biopsy of prostate, [Grabstald & Elliott] *563
tumors, program for detecting polyps, [Giantureo & Miller] *1429
RECURRENT FEVER: See Relapsing Fever
RED CELLS: See Erythrocytes
RED CROSS
Belgian, organizes campaign for good milk, 873
RED CROSS, AMERICAN
adopts changes in first aid techniques, 1106
REDUCING Diet; Treatment: See Obesity treatment
REFLEX
activity, return of, in paraplegia, [O'Connell & Gardner] *706
patellar, "jerk" in other leg in brain injuries, 456
REFRESHER Courses: See Education, Medical courses
REFRIGERATION
Therapeutic Use: See Cold, therapeutic use
REFRIGERATORS
obsolete, warning against, N. Y., 1369
REGIONAL ENTERITIS: See Intestines inflammation
REGISTER; Registry: See Beryllium poisoning; British Medical Register; General Register Office
REHABILITATION
American Board of: See American Board
A.M.A. Council on Physical Medicine and: See American Medical Association
Peoria Plan for, Dr. Vonachen honored, 1025
pilot project, N. Y., 1290
REISS Memorial Lecture: See Lectures
RELAPSING FEVER
treatment, oxytetracycline (terramycin) [Gefel] 765—ab
RELAXANTS: See Muscles
RELIGION
magic, and medicine, London, 971
RELTINE Hydrochloride: See Piperphenidol Hydrochloride
REMEDIES: See Drugs
REMER Lecture: See Lectures
REMUNERATION: See Fees; Wages
RENAL: See Kidneys
Glycosuria: See Glycosuria
Rickets: See Osteodystrophy, renal
REORGANIZATION PLAN
No. 1; No. 6, 1953, (Committee report) 836
REPRODUCTION: See Coitus; Contraception; Fertility; Impregnation; Pregnancy; Sterility
RESEARCH: See also Animal Experimentation; Science; under specific headings as Cancer
clinical, in National Health Service, London, 1378
Fellowships: See Fellowships
Foundation: See Foundations
Grants for: See also Foundations
grants for, list of, given by A.M.A. Subcommittee on Grants-in-Aid, (report) 934
medical, and progress, Dr. McCormick's statement before U. S. House Committee, 730
medical, military, academic freedom in, [Kersner & Phillips] *1356
Medical Research Council: See Medical Research Council
National Research Council: See National Research Council
Newsletter No. 1 of College of General Practitioners, London, 1039
Prizes for: See Prizes
volunteers to aid, human thrombin source of hepatitis, [Porter & others] *17
RESERVES: See Army, U. S.
RESIDENCE: See also Home
of freshman students, in U. S. and Canada, 1952-1953, *124; *126; *127; *128
RESIDENTS AND RESIDENCIES: See also Fellowships; Interns and Internships
award for residents, N. J., 436
deferment of residents, *113
Number, September 26, page 275
private beds in medical teaching, [Armstrong] *82; 149—E
psychiatric residency training program, 580
residencies approved by A.M.A., *279; 431—E
residencies available at VA hospitals, (New York) 968; (Indianapolis) 1298; (N. Mexico) 1466
residencies by type of hospital control, (Council report) *280; *281
residencies, list of, according to specialties, *311
residencies, number by hospital bed capacity, (Council report) *281
residencies, number by specialties, (Council report) *280
residency training, list of hospitals approved for, (Council report) *375
RESINS
carbacrylamine, treatment of hypertension, [Gill] 1205—ab
ion-exchange, [Pannacciulli] 1321—ab
melamine, allergic contact dermatitis, [Conrad & Ford] *557
quinine carbacrylic, N.N.R., (description) 1362; (Squibb) 1362
RESPIRATION
artificial, Emerson Rocking Bed, Standard Hospital Model, 33
Disorders: See Asphyxia
emergencies in newborn, [Cooper & others] *1077
RESPIRATORY METABOLISM: See Metabolism, basal
RESPIRATORY SYSTEM: See also Bronchus; Lungs; Pleura; Trachea
Disease: See also Bronchiectasis; Laryngotracheobronchitis; Pneumoconiosis
disease, cause of death in physicians, [Poynton] 1379—C
disease from inhaling grain dust, [Cohen] 61—ab
disease in children, vitamin B_{12} and liver extract for, [Masi] 1129—ab
Fistula: See Fistula
function during altitude stress, [Marbarger] 1401—ab
Infection: See also Bronchopneumonia; Colds; Influenza; Pneumonia; Tuberculosis of Lung
infection and citrus fruit: case of Florida, 527
infection (nonbacterial), antibiotics in, [Jones & others] *262
RESPONSIBILITY: See Malpractice
REST: See Sleep
RESUSCITATION: See Respiration, artificial
Cardiac: See Heart
RETICULO-ENDOTHELIAL SYSTEM
Letterer-Siwe Disease: See Letterer
RETINITIS
proliferans in diabetic, 1597
RETIREMENT
A.M.A. resolution on UMWA Welfare program, 952
big pensions and big government, 959—E
funds for self-employed, Dr. McCormick's statement before U. S. House Committee, 151

153
953

RETIREMENT—Continued
Pensions for Self-Employed and the Pensionless Employed, (Bureau report) 844
physician and economist look at old-age and survivors insurance, [Blasingame & Dickinson] *921; 959—E
Retire to Life (film review), 1477
RETROLENTAL FIBROPLASIA
oxygen administration and, [Huggert] 452—ab
RETROPNEUMOPERITONEUM
in roentgenography of adrenals, Italy, 1468
REULING, JAMES R., address by Speaker of House of Delegates, *1527
REWARDS: See Prizes
Rh FACTOR: See also Erythroblastosis, Fetal
exchange transfusions in hemolytic disease of newborn, [Sacks] 1570—C
question of typing infants and newborn infants for transfusion, 727
RHEUMATIC FEVER
blood proteins (plasma or serum) in, [Jackson] 1574—ab
Cardiac Complications: See Heart disease (rheumatic); Heart inflammation; Myocarditis
convention on rheumatology, Italy, 746; 1178
pain and swelling in both knees, 693
pathogenesis of constrictive pericardium, [Moschcowitz] *1944
prevention: immune response in streptococcic infections, [Brock] 519—ab
preventive use of chlortetracycline (aureomycin), [McVay] 1402—ab
preventive use of sulfonamides and penicillin, [Roberts] 448—ab
reactivated after mitral commissurotomy, [Soloff] 1576—ab
recurrences, (reply) [Feldman] 528
RHEUMATISM: See also Arthritis
Acute Articular: See Rheumatic Fever
cement floors conducive to? 1414
immunity in, convention discusses, Italy, 746
in children, treatment sodium salicylate for, [Pellegrini] 1224—ab
International Congress of Rheumatic Diseases, Switzerland, 1302
Italian Society of Rheumatology, (convention) 746; (award) 1187; (Roman Rheumatological Days, Feb. 13-14, 1954) 1372
pathogenesis of rheumatic granuloma, [von Albertini] 1491—ab
treatment, cortisone combined with 5 drugs, [Ballabio] 1491—ab
RHEUMATOID ARTHRITIS: See Arthritis, Rheumatoid
RHINITIS
Vasomotor: See Hay Fever
RHINOLALIA
nasal speech, 1232
RIB: See Ribs
RIBOFLAVIN
U.S.P., N.N.R., (Hart Drug) 727
RIBS
surgery, emergency infracostal approach in cardiac arrest, [Wexler] 516—ab
surgery, plastic spreading to correct scoliosis, [Felix] 602—ab
RICE
Heinz Strained Rice and Cheese, 1521
RICKETS
in children, [Spies] *188
Renal: See Osteodystrophy, renal
RICKETTSIA: See Q Fever; Typhus
RIGIDITY
muscular, carbon dioxide inhalation in, (correction) 225
muscular, carbon dioxide inhalation in, vs. psychotherapy, [Leavitt] 509—C
RIGLER Lecture: See Lectures
RIMIFON: See Isoniazid
RING
black discoloration beneath gold ring, 455; (reply) [Brauer] 1416
RINGWORM of Scalp: See Tinea capitis
ROAD Accidents: See Automobile accidents
ROCH, MAURICE, retires, Switzerland, 1302
ROCKEFELLER
Foundation: See Foundations
ROCKING Method of Respiration: See Respiration, artificial
RODENSTOCK Eye Refractometer, 645
RODENTS
control classes of U. S. Navy, 1194
ROENTGEN RAYS
diagnosis, advantages of in pregnancy, [Barter] 218—ab
diagnosis of uterine disorders, [Davids] 514—ab
during pregnancy, 218—E
Examination: See Aorta; Colon; Blood Vessels; Brain; Bronchus; Gallbladder; Gastrointestinal Tract; Mediastinum; Spinal Canal; Thorax, chest x-rays
Irradiation: See Roentgen Therapy
localization of bronchopulmonary segments with laminography, [Adler] 1047—ab
roentgenography, award for research on, N. Y., 1456
ROENTGEN THERAPY
of breast cancer, [Hellig] 255—ab
of cancer of uterine cervix, [Maier] 255—ab
of Hodgkin's disease, 774
of malignant lymphoma, [Hynes] 1047—ab
of pituitary in diabetes mellitus, [Pais] 1586—ab
ROENTGEN THERAPY—Continued
of spleen in leukemia, bone marrow changes after, [Gunz] 1049—ab
platelet transfusion in post-irradiation hemorrhagic state, [Woods] 242—ab
plus radical mastectomy for breast cancer, [Smith] 1581—ab
plus raw egg yolks in bone sarcoma in children, [Krebs] 1408—ab
value in nasal sinusitis in children, (reply) [Levy] 1232
ROESLER de Villiers Foundation: See Foundations
ROMAN Society of Surgery, Italy, 505
RONIACOL: See β-Pyridyl Carbinol
ROOMS: See Flooring
RUBBING ALCOHOL: See Isopropyl Alcohol
RUBELLA
cerebral complications, 258
in pregnancy, allocate gamma globulin to prevent, 74
in pregnancy, pathologic signs in infant, [Tenschi] 1483—ab
treatment, convalescent blood, 1496
RUBEOLA: See Measles
RUDS METHOD for staining eosinophils, 1067
RUNYON (Damon) Memorial Fund: See Foundations
RUPTURE: See Aneurysm; Hernia; under specific organs and regions as Heart; Spine, intervertebral disk
RURAL COMMUNITIES: See also Farm; Farmers
A.M.A. Council on Rural Health: See American Medical Association
County Health Department: See Health
health activities, (Council report) 847
health conference, (report) 847; (Dallas) 858; (Denver) 962
health, joint meeting on, 733
scholarship fund, gifts to, Ky., 435

S

SMA FORMULA
convulsion in infants from, (Council report) 939; 1521
SABIN-Feldman Dye Test: See Toxoplasmosis
SACCHARIN
only artificial sweetening substance allowed, London, 1039; 1378
SACRAL REGION
lipoma syndrome cause of backache, [Schmidt-Voight] 598—ab
SAFETY
National Safety Council: See National Safety Council
SAILORS: See Seamen
ST. LOUIS Clinical Meeting: See American Medical Association
SALARIES: See Wages
SALICYLATES: See Acid, acetylsalicylic; Acid, p-aminosalicylic; Sodium salicylate
SALICYLAZOSULFAPYRIDINE (Azulfidine)
treatment of chronic ulcerative colitis, [Morrison] 1580—ab
SALIVARY GLANDS
cancer in mouse, filtrable agent causing, 150—E
SALMON Lecture: See Lectures
SALMONELLA
pullorum, acute ulcerative colitis due to; cis-aramphenicol cures, [Doenges] *1018
typhosa, antigens variations, Paris, 664
SALPINGECTOMY: See Oviducts
SALT: See also Sodium chloride
free diet and Jewish laws, [Kisch] 1472—C
free diet, Comstock Brand Dietetic Pack products, 1099
free diet, Dorset Brand Diet Pack products, 801
free diet, Matchless Brand Dietetic products, 217; 645
free diet, Overland Brand Dietetic Pack products, 1099
free diet plus 1-hydrazinophthalazine or dibenzyline in hypertension, [Gill] 1205—ab
losing syndrome, detecting during cardiac therapy with mercurial diuretics, [Silverman] 64—ab
losing syndrome, renal disease with, [Murphy] 449—ab
Poor Serum Albumin: See Blood proteins
SALVIOLI Vaccine: See Tuberculosis, immunization
SAN FRANCISCO
coroner vs. medical examiner system, [Turkell *1086; 1100—E
Meeting: See American Medical Association
SANATORIUM: See Nursing Homes; Tuberculosis
SAND, RENÉ, death, 1028; 1111
SANITATION: See also Health
Industrial: See Industrial Hygiene
meeting (7th) between Chile, Peru, and Bolivia, 1036
of crushed ice, 1101—E
progress in Africa, human factors in, 705—ab
SARCOIDOSIS
etiology, tuberculous, [Doepfmer] 686—ab
in armed forces, [Nelson] 753—ab
of myocardium, [Sales] 518—ab
primary pulmonary, [Löfgren] 981—ab
SARCOMA: See also Fibrosarcoma; Lymphosarcoma
SARCOMA—Continued
of bone, raw egg yolks plus roentgen therapy, [Krebs] 1408—ab
of breast, [Mounoyer] 596—ab
Yoshida, and free cell tumors, Japan, 47
SCALDS: See Burns
SCALP
Ringworm of: See Tinea capitis
SCANDINAVIAN: See Danish
SCARLET FEVER
treatment, artificial hibernation, France, 1196
SCHAUMANN-Besnier-Boeck Disease: See Sarcoidosis
SCHICK Lecture: See Lectures
SCHIRMER, JACOB S., investigation by Arkansas attorney general, 647—E; 665—Bl
SCHISTOSOMIASIS
bilharziasis control, pilot project in, 225
diagnosis, Brazil, 873
intestinal, as occupational disease, Brazil, 1565
SCHIZOPHRENIA: See Dementia Precox
SCHLOR iodine boiling test for pregnancy, [Reuthin] 1582—ab
SCHOLARSHIPS: See also Fellowships
for medical students, *151; 148—E
Jones (Everett O.) at U. of Washington, 1458
Manning (E. T.) memorial, in public health, 1103
rural fund, gifts to, Ky., 435
SCHOLASTIC Record: See Grades
SCHOOL CHILDREN: See Children
SCHOOLS: See also Education; Students; University
American School Health Association, 964
Children in: See Children, school
for Technologists: See Technologists
Grades: See Grades
health conference, Oklahoma, 650
health in action, new film in A.M.A. Motion Picture Library, 1367
National Conference on Physicians and Schools (4th), 151; 853; 858
of Basic Sciences: See Basic Sciences of Nursing: See Nurses and Nursing
Premedical Work: See Education, Medical premedical
Teachers: See Teachers
SCHOOLS, MEDICAL: See also Education, Medical; Graduates; Students, Medical; University; under names of specific schools
Air Force: See Aviation, U. S. Air Force
applicants to, statistics on, compiled by Assn. of American Medical Colleges, *126; *129
approved, *117
approved, in Canada, list of, *146
approved in Canada with enrollment by classes and name of executive officer, *116; *120
approved in U. S., list of, with enrollment by classes and names of executive officer, *114; *117
approved, total number of students enrolled in, *118
Association of American Medical Colleges, (survey of medical education by A.M.A. and) *106; 149—E; (number of applicants to medical schools in U. S. compiled by *126; *129; (first teaching institute) 652; 1025—E; (membership broadened) 1291
British, survey of general practitioner schemes in operation in, London, 445
calendars, *117
Class A, B, C, graduates and students in, 1910-1929, *119
cost of attending, *130; 148—E
descriptive list of, in U. S., *140
faculty, vacancies in instructional staffs, *132; 148—E
financial needs, (report) 942
financial support, *110; *131; 148—E
for executive study of ophthalmology, Havana, 1558
foreign, American medical students in, *134; *135
foreign, (Council report) 942
foreign, list of, *133; *134
graduates with baccalaureate degrees in, *120
in order of size to total enrollment, 1952-1953, *119
internship required, *128
internships affiliation by, and hospital bed capacity, *276; *277
major development in, *108
Medical Schools in the United States at the Midcentury by Deitrick and Berson, *106; 149—E; (review) 1325
National Commission on Accrediting, (Council report) 941
new, *132
new: Yeshiva University Albert Einstein College of Medicine, (photo) 1557
preceptorship programs, 1952-1953, *130
Premedical Work: See Education, Medical
private and governmental (state and municipally owned) *131; 148—E
residence of freshman students, in U. S., and Canada, 1952-1953, *124; *126; *127; *128
responsibility for other students, *120; *121; *122
Stanford Medical School to move to Palo Alto, Calif., 153
Statistics on, September 12, 1953, page 105
Teaching in: See Education, Medical
tuition fees (annual), range of, *130
veterans in, *126
visited by A.M.A. Council, (report) 945

SCIENCE: See also Research
Basic Sciences: See Basic Sciences
fellowships and funds for world wide advancement of, [Trimble] *1146
International Congress of History of (7th), Israel, 745; 976
Medical: See Medicine
National Science Foundation: See Foundations
Pacific Science Congress (8th), 1027
writers, National Association of, (new headquarters) 1188
SCIENTIFIC
Exhibit: See American Medical Association, Scientific Exhibit
Publications, Translations of: See Journals
SCLERODERMA
progressive, [Beigelman] 759—ab
progressive, and Raynaud's syndrome, [Ferrari] 596—ab
SCLEROSIS: See also Arteriosclerosis; Liver cirrhosis
amyotrophic lateral, [Arnold] 979—ab
amyotrophic lateral, study of, by USPHS, 659
Hereditary (Spinal Form): See Ataxia, Friedreich's
progressive systemic, [Beigelman] 759—ab
Spinal: See Tabes Dorsalis
tuberous, histopathology, [Hallervorden] 1582—ab
SCLEROSIS, MULTIPLE
booklet for patients: "Mental Health and MS", 1292
disseminated, [Compston] 1128—ab
histopathology, [Hallervorden] 1582—ab
National Multiple Sclerosis Society, [Kresge Foundation grant to] 1105
treatment, massive doses of vitamin B12, [Lerebollet] 601—ab
SCLEROTHERAPY: See Varicose Veins
SCOLIOSIS: See Spine curvature
SCRATCHES
Cat Scratch Disease: See Cats
SCREENING, Multiple: See Diagnosis
SEA: See Submarines
SEAMAN Prize: See Prizes
SEAMEN
seasick, cures for, Denmark, 445
SEASICKNESS
cures for, Denmark, 445
SEASONS: See Meteorology
SECOBARBITAL (Seconal)
Sodium, N. N. R., (Chemo) 925
SECONAL: See Secobarbital
SECTION of . . . . : See American Medical Association, Section
SECTIONS: See Tissues
SECURITY: See Social Security
SEDGWICK Medal: See Prizes
SEIZURES: See Convulsions; Epilepsy
SELECTIVE SERVICE: See Medical Preparedness
SELF-MEDICATION
with bishydroxycoumarin, hemorrhage from, [Cosgriff] *547
SEMEN: See also Spermatozoa
Artificial Insemination: See Impregnation, artificial
pH of, relation to conception, [Tyler] *1351
SEMINOMA: See Dysgerminoma
SENILITY: See Old Age
SENSATION: See also Numbness: Paresthesia
burning in esophagus after gastrectomy, 1597
burning, in mouth, 1498
Loss of: See Anesthesia
SENSES: See Hearing; Vision
SENSITIVITY; Sensitization: See Allergy
SEPTICEMIA: See Meningococcemia
SERIALS: See Journals
SERODIAGNOSIS: See Brucellosis; Syphilis
SEROSITIS
polyserositis, pathogenesis of constrictive pericardium, [Moschcowitz] *194
SERUM
Blood: See Plasma; and subheads under Blood
convalescent, therapeutic use, 1496
Hepatitis: See Liver Inflammation
human, agglutination of "free-living" Endamoeba trophozoites by, Brazil, 47
Immune Serum Globulin: See Immune Globulin
Plasma: See Plasma
Sickness: See Allergy
SERUTAN
esophageal obstruction from; liquid Takadiastase relieves, [Johnson] 235—C
SERVICEMEN: See also Armed Forces; Army, U. S.; Medical Preparedness; Navy, U. S.; Soldiers; Veterans
dependents, Citizen's Advisory Commission on Medical Care of, President's page, 1178
dependents, medical care for, (Council report) 841
dependents, maternity and infant care provisions for, (Council article), [Carter & others] *51
Readjustment Act: See G. I. Bill
SERVING the public, 647—E
SEX: See also Fertility; Sterility
distribution of medical students by, *123; *126
factor in myasthenia gravis, [Schwab & Leland] *1270
Function, Development of: See Adolescence
SEX—Continued
Function, Decline of: See Menopause
Glands: See Gonads
Hormones: See Androgens; Estrogens
Impotence: See Impotence
Intercourse: See Coitus
Intergrades: See Hermaphroditism
"Kinsey report" of young Danish women, 1300
Kinsey report: pubococcygeus muscle and sexual physiology of vagina, [Kegel] 1303—C
Masculinization: See Virilism
Perversion: See Masturbation
SEXUAL STERILIZATION: See Sterilization, Sexual
SHAKING Palsy: See Paralysis agitans; Parkinsonism
SHATTUCK Lecture: See Lectures
SHAVING
the eyebrow, 1142
SHEDLOVSKY MOBILOMETER
changes in consistencies of commercial contraceptives, (Council article) [Gamble] *1019
SHERMAN Anti-trust Act: See Medicolegal Abstracts at end of letter M
SHIGELLA
sensitivity of to antibiotics in vitro, [Felsen & Wolarsky] *1071
SHINGLES: See Herpes zoster
SHIPS: See Navy; Seaman; Submarines
SHOCK
Allergic: See Allergy
Electric, Therapeutic: See Electric shock treatment
like state from blood contaminated with gramnegative bacilli, [Braude] 585—ab
treatment, arterenol, [Skelton] 595—ab; [Moyer] 1311—ab
treatment, polyvinylpyrrolidone, [Cordice] 520—ab; 1211—ab
tubular nephrosis in, [Moon] 589—ab
SHOEMAKERS
tuberculosis in, 233; [Stewart] 982—ab
SHOES: See also Hosiery
effects on foot form, [Knowles] 69—ab
hallux valgus, London, 972
SHOOTING: See Firearms
SHORT WAVE: See Diathermy; Radio; Television
SHOULDER
hand syndrome, sympathetic block vs. corticotropin and cortisone for, [Steinbrocker & others] *788
SHUNT
Operation: See Portal Vein
SHWARTZMAN PHENOMENON
generalized, relation to fatal complications of pregnancy, [McKay] 1206—ab
SICK: See Disease, chronic; Patients
Headache: See Migraine
Transportation of: See Ambulances
SICKNESS: See Disease
Absenteeism because of: See Industrial Health, workers
Insurance: See Insurance, sickness
Prevention: See Preventive Medicine
Rate of: See Vital Statistics, morbidity
Serum: See Allergy
SIGHT: See Vision
SIGMOID: See under Colon
SILICOSIS: See Pneumonoconiosis
SILKWORTH Memorial Service of Knickerbocker Hospital, N. Y., 1558
SILO
cause of death in, 893
SIMULATION: See Malingering
SINUS
Carotid Sinus: See Carotid Sinus
SINUSES: See Skin
SINUSITIS, NASAL
focus of infection in eye lesions, [Wellie] 1121—ab
in children, 456; (reply: value of roentgen therapy) [Levy] 1232
SIWE-Letterer Disease: See Letterer-Siwe Disease
SKELETON: See Bones
SKEPTOPHYLACTIC method of vaccination, (reply) [Little] 694
SKIM Milk: See Milk
SKIN: See also Dermatology; Tissues
Allergy: See Dermatitis venenata; Eczema
biopsy to detect chromosomal sex in hermaphrodites, [Moore] 65—ab
black discoloration beneath gold ring, 455; (reply) [Brauer] 1416
Burn: See Burns
cancer, dermatologist role in therapy, [Lamb] *1509
cleansing before smallpox vaccination, 1327
Creams or Cosmetics: See Cosmetics
Disease: See also Dermatitis; Eczema
disease, capillary microscopy, Norway, 1471
disease, corticotropin and cortisone in, [King] 1403—ab
disease, in Belgian Congo, 873
disease in kwashiorkor, (Council article) [Williams] *1282
Disease (Industrial): See Industrial Dermatoses
disease, oxytetracycline for, [Robinson] 1213—ab
eosinophilic granuloma of, Brazil, 969
SKIN—Continued
Fish Skin: See Ichthyosis
grafting in surgical separation in craniopagus (Brodie twins), (Grossman & others] *201
Hemorrhage: See Purpura
infections, erythromycin locally for, [Livingood & others] *1266
Inflammation: See Dermatitis
Itching: See Eczema; Pruritus
Mycosis: See Chromoblastomycosis
pigmentation, dyspigmentation in kwashiorker, (Council article) [Williams] *1282
pigmentation in intermarriage, (reply) [Whipple] 894
preparations of antihistamines omitted from N.N.R., 1447
Reaction: See Allergy; Dermatitis venenata
resistance encountered in making electrocardiograms, 893
Scleroderma: See Scleroderma
sensitization to antibiotics in medical personnel, London, 583
sinuses of dental origin, [Gurdin] 594—ab
sutures, removal of: additional technics, [Kazmierski; Etzel; Ivy; Schneider] 235—C
Test: See Tuberculin
Transplantation: See Skin grafting
tumors, excision of, 776; (reply) [Fulmer] 1498
Ulcers: See Ulcers
SKULL: See Cranium
SLEEP
Induced: See Anesthesia
Induced (Narcosis): See Narcosis
SLEEPING DISEASE: See Trypanosomiasis
SMALLPOX
Vaccination: See also Vaccinia
vaccination, cleansing skin before, 1327
vaccination, encephalitis after, [André-Baliseaux] 1320—ab
vaccination, neurological illness after, [Miller] 512—ab
vaccination of child with eczema, (replies) [Baldridge; Little] 694
vaccine, improvement, Paris, 584
SMELL: See also Odor
SMITH, KLINE AND FRENCH LABORATORIES
color television program, St. Louis Clinical Meeting, Dec. 1-4, 813; 1100—E
SMOG
in London, 1566
SMOKE
Atmospheric: See Air
SMOKERS; SMOKING: See Tobacco
SNAKES
bite by coral snake, treatment, 178; (reply) [Varga] 1232
rattlesnake venom, intermediate nephron nephrosis in poisoning from, Brazil, 1376
SOAP
surgical, Hexachlorophene, N.N.R., (Central Chemical) 1447
Surgi-Cyn (liquid), N.N.R., (Central) 1447
SOCIAL SECURITY
Act, (Council report) 843
physician and economist look at old-age and survivors insurance, [Blasingame & Dickinson] *921; 959—E
SOCIALIZED MEDICINE: See Insurance, sickness; Medicine, socialized
SOCIETIES, MEDICAL: See also American Medical Association; Association; under names of specific societies; list of Societies at end of letter S
county, activities, 954; 961
county, 50th year, (Montgomery County, Md.) 1455; (Edgar County, Ill.) 1556
county, Grievance Committees, (Council report) 494; *510; 955
Grievance Committees, A. M. A. new publications, 961
Know your state and local society, resolution for 1954, Dr. McCormick's page, 1525
membership regulations, uniformity needed, [Cargill & Tracy] *1179
private practice in small industry, [Ricke] *198
rules for setting fees, [Business Practice] *1202
state, full extent of activities of, Rhode Island, 553—ab
state, home for, Wis., 651
State Journals: See under Journals
state, mental health activities, 931
State Physician Placement Service: See Physicians, placement
Woman's Auxiliary: See Woman's Auxiliary
World Medical Association: See World Medical Association
SODIUM
p-Aminosalicylate: See Acid, *p*-aminosalicylic, sodium salt
Ascorbate: See Acid, ascorbic, sodium salt
Chloride: See also Salt
chloride, glucose in, give simultaneously with whole blood: (reply) [Gibson] 258
cobaltinitrite to determinate serum potassium, [Keitel & Keitel] *799

153
953

SODIUM—Continued
content (bulb) of softened water, (reply), [Shewman] 694
dehydrocholate, N.N.R., (Lincoln Laboratories) 727
hydroxide, plastic reagent bottles for [Cornbleet] 1571—C
in meat processed by Jewish law, [Klsch] 1472—C
morrhuate injection, phlegmasia cerulea dolens after, [Nelson] 977—ab
nucleicate, yeast fraction protects against infection, [Parfentjev] 1581—ab
radioactive, clearance to determine muscle blood flow, [Wisham & others] *10
salicylate in children, [Pellegrini] 1224—ab
salicylate plus cortisone etc. in rheumatic disease, [Ballablo] 1491—ab
salicylate treatment of gout, [Marson] 1590—ab
Secobarbital: See Secobarbital
sulfacetamide, N.N.R., (Chemo) 925
SOIL
dust from, chest pain in farmers from exposure to, [Williams] 164—C
SOLDIERS: See also Armed Forces: Army; Medical Preparedness; Servicemen; Veterans
coronary disease in, [Sigler] 664—C
SOLUTION: See under specific names as
Potassium arsenite
Ophthalmic: See Eyes
SOLVENTS
acute poisoning with tetrachlorethane, [Sherman] 886—ab
SOMATIC
Complaints: See Psychosomatic Medicine
Development: See Growth
SOUND: See Heart sounds; Noise
Waves: See Ultrasonics
SOUP
Dorset Brand Diet Pack Condensed, 801
SOUTH AMERICA: See also Pan American
expedition to; want to recruit young American medical graduate, [Acworth] 235—C
SPASM: See also Contracture; Cramps
Diaphragmatic: See Pleurodynia, Epidemic
treatment, prostigmin, in arthritis, [Howell] 1583—ab
treatment stellate ganglion block [Ruben & Mayer] *1002
SPEAKERS: See also Speech
scientific, wanted by Illinois State Medical Society, 153
SPEAKING: See Speech; Voice
SPECIAL LIBRARIES ASSOCIATION translation pool, 1371
SPECIALISTS: See under specific names as
Pathologists; Pediatricians
Certification: See American Board
SPECIALTIES: See also under types of specialties as Ophthalmology; Pathology
approved examining boards in, [Kirklin] *389
approved residencies and fellowships according to, Council report, *311
number of residencies by, Council report, *280
postgraduate continuation courses according to, for 1954, 1365—E; *1381
SPECIFIC GRAVITY
of urine as test of renal function, [Goldring] *1245
SPEECH: See also Speakers; Voice
Barkhorn Memorial Speech and Hearing Center, N. J., 569
nasal: rhinolalia, 1232
SPERMATOZOA
azoospermia, [O'Conor] *532
azoospermia: role of pituitary; hormone injection overdone, (reply) [Weisman] 694
requirements for conception, [Tyler] *1353
SPHINCTER MUSCLES
of Oddi, fibrosis, [Cattell] 213—ab; 516—ab
SPIDERS
bites from, necrotic arachnidism, [Mackinnon] 1582—ab
SPINAL ANESTHESIA: See Anesthesia, spinal
SPINAL CANAL
roentgen study, fatal late meningeal reaction to Pantopaque, [Erickson & van Baaren] *636
roentgen study, in avulsion of brachial plexus, [Jaeger & Whiteley] *633
SPINAL CORD
avulsion of brachial plexus from, [Jaeger & Whiteley] *633
compression from myeloma, neurosurgical treatment, [Svien & others] *784
compression from skeletal fluorosis, [Murthi] 983—ab
Disease: See also Encephalomyelitis; Poliomyelitis
disease, diabetic myciopathy, [Garland] 685—ab
inflammation after smallpox vaccination, [Miller] 512—ab
inflammation and necrosis fatal after intercostal use of efocaine, [Angerer & others] *550
injuries, decubitus ulcers, dried blood plasma-Peruvian balsam paste for, [Clark & Rusk] *787
lupus erythematosus involving, resulting paralysis of legs, [Piper] *215
Sclerosis: See Sclerosis Multiple
SPINAL CORD—Continued
surgery, cordotomy in high cervical region for intractable pain, [French] 682—ab
SPINAL FLUID: See Cerebrospinal Fluid
SPINAL INJECTION: See Injection, spinal
SPINE: See also Atlas; Ribs
arthritis, rheumatoid spondylitis, Marie-Strümpell disease, 257
curvature, adolescent kyphosis, [Dameron] 250—ab
curvature, correct scoliosis by plastic spreading of ribs, [Felix] 602—ab
fractures (asymptomatic) in aged, [Gershon-Cohen & others] *625
fracture, cord bladder from, [Thompson] *1337
fracture, whiplash injuries of neck, [Schaefer] 974—C
intervertebral disk (displaced), 1414
intervertebral disks, discographic diagnosis in herniation, [Davies] 681—ab
intervertebral disks (lumbar), herniation, [Gage] 241—ab
tuberculous spondylitis, statics of vertebral column in treatment, of, [Kaiser] 603—ab
tumors, chordoma of lumbar vertebra, [Baker] 62—ab
SPIROCHETE Infection: See Relapsing Fever
SPLEEN
Enlarged: See Splenomegaly
Excision: See Splenectomy
irradiation in leukemia, bone marrow changes after, [Gunz] 1049—ab
portal venography, via, [Rousselot] 1403—ab
symptoms of, poliomyelitis, [Kalk] 1218—ab
SPLENECTOMY
in complications of gold therapy, [Watson] 686—ab
in congenital hemolytic anemia in Negro brothers, [Irby] *1103
in cyclic neutropenia (at 21-day intervals), [Coventry] *28
SPLENOMEGALY
Banti's syndrome, bleeding esophageal varices in, [Linton] 168—ab
Banti's syndrome, portal vein obstruction, [Marion] 1592—ab
lead absorption increased from pica, [van Wisselingh] 69—ab
SPLINT
for mallet finger, [Spigelman] *1362
SPONDYLARTHRITIS: See Spine arthritis
SPONDYLITIS: See Spine
SPONGE
Polyvinyl: See Polyvinyl Sponge
SPORTS: See Athletics
SPOT REMOVER
hazardous dry cleaning agents, 1232
SPRAIN
cold treatment, 1142
SPREADING FACTOR: See Hyaluronidase
SPRUE
Nontropical: See Celiac Disease
tropical, blood pressure in steatorrhea, [de Langen] 1324—ab
SPUTUM
bacteriology of chronic bronchitis, [May] 1487—C
endobronchial method to increase bacillary content, [Fourestier] 601—ab
STAINLESS Steel: See Steel
STAINS and STAINING
permanganate stains, removal of, 258; (replies: use oxalic acid) [Palmer; Evans] 894
staining eosinophils, 7 methods, 1067
Sudan 3 for staining lipid bodies in urinary sediment, [Magath] 1041—C
STAMPS: See Postage Stamps
STANDARD Nomenclature of Diseases and Operations: See Terminology
STANFORD UNIVERSITY Medical School to move to Palo Alto, Calif., 153
STAPHYLOCOCCUS
aureus, spread of, in maternity department, [Barber] 1323—ab
enteritis, (fatal) after penicillin and streptomycin therapy, [Fairlie & Kendall] *90
gastroenterocolitis after using antibiotics, [Terplan] 1181—ab
infections of skin, erythromycin locally for, [Livingood & others] *1266
infections (surgical), antibiotics to control, [Maloney & Johnson] *1253
STATE
Board: See State Board *following*
Health Department: See Health
Hospital: See Hospitals, psychiatric
Journal Advertising Bureau: See American Medical Association
Journals: See under Journals
Legislation: See Laws and Legislation
owned medical schools, *131
Physicians Placement Service: See Physicians, placement
Society: See Societies, Medical
STATE BOARD: See also Licensure
requiring one year internship, *128
STATEMENTS, Physicians': See Fees
STATISTICS: See also Schools, Medical; Vital Statistics
drama in, 1177—E
fellowships in at U. of Chicago, 1288
STEATORRHEA: See Feces, fat in
Idiopathic: See Celiac Disease
STEEL
stainless, cable, to repair ruptured patellar tendon, [Chandler] *1093
STELLATE Ganglion Block: See Ganglion
STENEDIOL: See Methylandrosienediol
STERILITY, BACTERIAL: See also Sterilization, Bacterial
of surgical linen, [Propst] 1489—ab
STERILITY (SEXUAL): See also Impotence
American Society for Study of Sterility, (award for research) 497; (meeting, Nov. 6-8) 866
in men, endocrine aspects, [Bishop] *534
in men, mechanical aspects and surgical management, [O'Conor] *532
Inducing: See Sterilization, Sexual
Institute for Research on Infertility, Israel, 1188
of unknown cause, [Tyler] *1355
peritoneal factor in, [Murray] 1577—ab
Treatment: See Impregnation, artificial
STERILIZATION, BACTERIAL: See also Antisepsis
by dry heat, 1327
STERNUM
Anomalies (funnel chest): See Thorax
STETHOSCOPE
amplifying, for physician who has had hearing loss, 776
vs. unnecessary laboratory tests, 997—ab
STIGMONENE Bromide: See Benzpyrinium Bromide
STILBAMIDINE
isethionate, N. N. R., (description) 1174; (Merrell) 1175
treatment of blastomycosis in tuberculous patient, [Stilllans & Klemptner] *560
STILBESTROL: See Diethylstilbestrol
STILL'S Disease: See Arthritis, Rheumatoid
STILLBIRTH
statistics, Italy, 506
STIPENDS: See Wages
STOCK (livestock): See Animals
STOCKINGS: See Hosiery
STOKES-Adams Syndrome: See Heart block
STOMACH: See also Digestive System; Gastro—
achylia, increased lead absorption resulting from pica, [van Wisselingh] 69—ab
acidity, proteolysis in anacidity, [Bramstedt] 68—ab
acidity, quinine carbacrylic resin, N.N.R., (description) 1362; (Squibb) 1362
amyloidosis involving, [Cooley] 1122—ab
cancer, [Abrahamson] 978—ab
cancer, early diagnosis, Finland, 1377
cancer, malignant ulcer, [Smith & others] *1507
cancer, 5 year survival rate, [Raffl] 680—ab
cancer, surgical treatment, [Kirschner] 678—ab
cancer, symptoms after gastrectomy, 1068
cardiospasm, esophagus in general practice, [Thorek] *703
decompensation, [Gibb] 1316—ab
Disorder: See Indigestion
diverticula, [Sommer & Goodrich] *1424
evacuation of high-fat meals, effect of vagotomy, [Waddell] 61—ab
Excision (Gastrectomy): See Stomach surgery
foreign bodies, diospyrobezoar, [O'Leary] 587—ab
foreign bodies, phytobezoar from eating wild dates, Turkey, 1471
gastrocardiac syndromes, Italy, 232
gastroscopic diagnosis of gastric ulcer, [Schindler] 1313—ab; [Smith & others] *1505
gastroscopy, meperidine intravenously before, [Cimoch & Wirts] *1004
Hemorrhage: See also Hematemesis; Peptic Ulcer, hemorrhage
hemorrhage, difficulty in recognizing, 1287—E
hemorrhage, thrombin (Topastasin) for, [Uster] 1061—ab
pain, patterns of, 556—ab
roentgen study in ulcer, [Smith & others] *1506
roentgen study, limitation in, [Swenson & Jeffrey] *1123
rupture of syphilitic thoracic aneurysm into, [Renner & Sindelar] *102
secretion, effect of anticholinergic drugs, [Ruffin & others] *1159
secretion, human gastric juice action on blood clots, [Barkhan] 882—ab
secretion, hypothalamus and hydrochloric acid secretion, [Porter] 249—ab
studies on, Paris, 48
Surgery: See also Gastroenterostomy; Peptic Ulcer, surgical treatment; Stomach cancer
surgery, burning sensation in esophagus after gastrectomy, 1597
surgery, clinical analysis of Billroth 1 and 2, subtotal resections, [Moore] 676—ab
surgery, fundic gastrectomy, [Leger] 1131—ab
surgery, postoperative jejunal ulcer, Brazil, 745
surgery, symptoms after gastrectomy, 1068
surgery, total gastrectomy, Brazil, 1299
surgery, ulcer recurring after resection, [Walters & Chance] *993
tumors, polypoid, 455
Ulcer: See Peptic Ulcer

V 15
1953

STOOLS: See Feces
STONES: See Calculi (cross reference)
STORAGE
of Blood: See Blood Transfusion
storing ampuls for spinal anesthesia: use of color indicator, [Lewis] 50—C
STRAIN: See Effort; Stress
STRAUSS Lecture: See Lectures
STREET
Accidents: See Automobiles, accidents
STREPTOCOCCUS
carrier and disease, penicillin as preventive, [Wannamaker] 593—ab
Infection: See also Endocarditis; Rheumatic Fever; Scarlet Fever
infection, immune response in, [Brock] 519—ab
infection of skin, erythromycin locally for, [Livingood & others] *1266
Infection, penicillin prophylaxis, Denmark, 1112
toxin-antitoxin to induce arterial sensitization, [Mokychic] 1211—ab
STREPTOKINASE-STREPTODORNASE (Varidase)
decoagulation process in enzymatic decortication, [Halse] 687—ab
in thoracic empyema, [Finnerty] 763—ab
STREPTOMYCIN
Dihydro—: See Dihydrostreptomycin
in spinal fluid in tuberculous meningitis, [Pani] 688—ab
intestinal antiseptic, [Poth] *1516
sensitivity of strains of Koch's bacillus, [Bertoye] 689—ab
toxicity: eighth nerve damage, 990
toxicity: fatal staphylococcus enteritis, [Fairlie & Kendall] *980
toxicity, neurotoxicity, [Winston] 752—ab
Treatment: See also Meningitis, tuberculous; Tuberculosis; Tuberculosis of Lung
treatment of pulmonary tuberculosis vs. 5 other agents, [Tempel] 589—ab
treatment plus dihydrostreptomycin in pulmonary tuberculosis, [Cohen] 754—ab
treatment plus iodine, stilbamidine, and ethyl carbilate in blastomycosis in tuberculous, [Stilliams & Klempiner] *560
treatment plus isoniazid, [Hobby] 240—ab
treatment plus isoniazid in miliary tuberculosis and tuberculous meningitis, [Ritchie] 1223—ab
treatment plus PAS and isoniazid in renal tuberculosis, [Lattimer] 172—ab
treatment plus PAS, and isoniazid in tuberculosis, Denmark, 1360; (in "swing therapy") [Tanner] 1407—ab; [Jensen] 1594—ab
treatment plus PAS and thiosemicarbazone in tuberculosis, Turkey, 1471
treatment plus PAS or isoniazid in pulmonary tuberculosis, bacterial resistance to, [Medical Research Council] 1059—ab
treatment plus penicillin in urology, [Sträuhle] 1489—ab
treatment plus sodium sulfacetimide for intestinal obstruction, Brazil, 162
treatment, resistance in tuberculosis, [Turnbull] 251—ab; [Medical Research Council] 1059—ab
treatment to control surgical infections; [Meleney & Johnson] *1253
treatment vs. dihydrostreptomycin, [Mahady] 754—ab
STREPTOTRICHOSIS: See Actinomycosis; Nocardiosis
STRESS
adrenal cortex and, interdependent effect on sugar metabolism, [Burns] 979—ab
Annual Reports on, reprints, [Selye & Horava] 1115—C
cause of death of physicians in relation to, [Poynton] 1379—C
effect of transfusion, [Möller] 770—ab
effect on asthma, [Feinberg] 682—ab
psychic factors role in myocardium infarction, [van Balen] 1489—ab
"STROKES": See Brain hemorrhage
STRONG, RICHARD, Philippine memorial gift, Mass., 569
STRUMA: See Goiter
STUDENTS: See also Children, school; Schools; University
in Schools of Basic Sciences: See Basic Sciences
medical examination, Belgium, 1111
STUDENTS, MEDICAL: See also Education, Medical; Graduates; Interns and Internships; Schools, Medical
A.M.A., (report) 957
American, at Hebrew University-Hadassah Medical School, Israel, 231
American, in foreign medical schools, *134; *135
British Medical Student Ass'n. "Survey for the General Practitioner Schemes in Operation in British Medical Schools", 445
day in Galveston and Houston, 1291
deferment, eligibility for consideration, *112
distribution by sex, *123; *126
Fees: See Schools, Medical, tuition
Fellowships: See Fellowships
Foreign: See Physicians, foreign
freshmen class (1953), *129
STUDENTS, MEDICAL—Continued
freshmen, residence of, in U. S. and Canada, 1952-1953, *124; *126; *127; *128
freshmen, scholastic college record (grades), *129
in approved schools in U. S., 1910-1953, *119
In required intern year in U. S., 1931-1953, *118
loan funds, *131; 148—E; (Illinois) 673; (Texas) 1475
medical schools responsibility for, *120; *121; *122
Negro, *126
number by classes, *114; *117
number from each state applying to one or more medical schools, *126; *129
Scholarships: See Scholarships
Teaching: See Education, Medical
total number enrolled in approved schools, *118
veterans, *126
women, *123; *126
SUBARACHNOID Hemorrhage: See Meninges hemorrhage
SUBMARINES
medicine, [Fulton] *487
SUCCINYLCHOLINE
chloride, N. N. R., (description) 726; (Abbott) 727; (Burroughs Wellcome) 727
SUCCINYLSULFATHIAZOLE (Sulfasuxidine)
intestinal antiseptics, [Poth & others] *1516
SUDAN III
stain for lipid bodies in urinary sediment, [Magath] 1041—C
SUGAR: See also Carbohydrates; Glucose
in Blood: See Blood
in Urine: See Diabetes Mellitus
substitutes: artificial sweeteners in food, London, 1039; 1378
SUGGESTION, Mental: See Hypnosis; Psychotherapy
SUICIDE
medicolegal experiences under Ohio coroner's system, [Landé & Boone] *179
SULFACETAMIDE
N.N.R., (Chemo Puro) 1175
sodium, plus streptomycin for intestinal obstruction, Brazil, 162
SULFADIAZINE
treatment plus penicillin in pneumonia, (Krasnus) 1593—ab
U.S.P., N.N.R., (Bowman Bros.) 1175
SULFAGUANIDINE
intestinal antiseptics, [Poth] *1516
SULFASUXIDINE: See Succinylsulfathiazole
SULFATHALIDINE: See Phthalylsulfathiazole
SULFATHIAZOLE
Succinyl —: See Succinylsulfathiazole
Phthalyl —: See Phthalylsulfathiazole
SULFOBROMOPHTHALEIN SODIUM
clearance test, [Goodman & Kingsley] *462
SULFONAMIDES
Combination: See Meth-Dia-Mer-Sulfonamides
prophylactic use in rheumatic fever, [Roberts] 448—ab
Sulfadiazine: See Sulfadiazine
Sulfaguanidine: See Sulfaguanidine
treatment vs. antibiotics in bacillary dysentery, [Felsen & Wolarsky] *1071
p,p'SULFONYLDIANILINE (DDS)
effect on Nocardia brasilliensis, Mexico, 446
SULFUR: See also Acid, sulfuric
black discoloration beneath gold ring, 455; (reply) [Brauer] 1416
SUNLIGHT
actinic dermatitis, 1232
flavor in milk, 1076—ab
SUPERSONICS: See Ultrasonics
SUPERSTITION: See also Magic
regarding disease in India, [Bowers] *1168
SUPREME Court: See Medical Jurisprudence
SUPPURATION: See Abscess; Otitis Media; Ulcers
SUPRARENALS: See Adrenals
SURGEONS: See also Medicine, profession of; Physicians; Surgery
flight surgeons needed, Conn., 1556
International College of, Italian section, 582
Surgeon General: See Navy, U. S.
SURGERY: See also under specific diseases, organs and operations as Abdomen; Adenoidectomy; Cesarean Section; Peptic Ulcer, surgical treatment; Splenectomy; Stomach surgery; Thyroidectomy; Tonsillectomy
American Board of: See American Board
Amputation: See Amputation
Anesthesia in: See Anesthesia
by direct vision in open heart during hypothermia, [Swan & others] *1081
course postponed at U. of Oklahoma, 1558
Hypotension (Controlled) during: See Blood Pressure, low
Infections in: See Infection, surgical
Inflammation, oxytetracycline in, [Schultz] 1489—ab
medicosurgical meeting, (Italy) 1037; (Chile) 1565
Moving Pictures Concerned with: See Moving Pictures, Medical (Reviews)
Neurosurgery: See Neurosurgery
operating rooms, conductive flooring for, to guard against explosions, 608
SURGERY—Continued
operating rooms, normal bacterial count in, 775
Optration (illegal): See Abortion, criminal
Panamerican Congress of, Brazil, 162
penicillin therapy (intermittent massive) [von Lutzki] 1226—ab
plastic, hypotensive anesthesia in, [Bentel] 601—ab
plastic, new Hadassah departments in, Israel, 746
Plastic Surgery, American Board of: See American Board
porphyria in, [Kergin] 1486—ab
Postoperative Conditions: See under specific conditions as Thrombosis; Urine retention
postoperative patients, Thorn's test in, [Grassi] 985—ab
risk in aged, International College discusses, Italy, 582
Roman Society of, Italy, 505
Standard Nomenclature of Diseases and Operations: See Terminology
survival of the young and the aged, 728—E; (elderly more susceptible to anoxia) [May] 1570—C
Sutures: See Sutures
Sympathectomy: See Sympathectomy
temperature and pulse of patients, [Peters] 1321—ab
traumatic, hyaluronidase in, [MacAusland] 1314—ab
Watts chair of, bequest to establish, Va., 651
SURGICAL
Instruments: See Instruments
Linen: See Linen
Soap: See Soap
Sutures: See Sutures
SUTURES
circumcision according to Jewish rite, 1497
skin, removal: additional technics, [Kamzmierski; Etzel; Ivy; Schneider] 235—C
SWALLOWING
difficult, in newborn, [Cooper & others] *1079
SWEAT
black discoloration beneath gold ring, 455; (reply) [Brauer] 1416
congenital hyperhidrosis, hydergine and banthine for, [Carson] 1212—ab
sweating of feet from radiant heated floor? 1414
SWELLING
in both knees and pain, 693
unexplained, 692
SWIFT'S
Strained Egg Yolks for Babies, 1099
SWIMMING
bathing water quality and health, [Stevenson] 513—ab
SWIMMING POOL
Dr. R. E. Kriz presents pool to home town, Neb., 736
water, odor of, 178
SWINDLERS: See Quackery
"SWING Therapy": See Tuberculosis of Lung
SWISS
Association Against Tuberculosis, 1038
Gynecological Society discusses androgen therapy in gynecology, 1468
SYDENHAM'S Chorea: See Chorea minor
SYMPATHECTOMY
treatment of causalgia, [Barnes] 1220—ab
treatment of frostbite, [Isaacson] 249—ab
treatment plus adrenalectomy in severe hypertension, [Jeffers] 880—ab; [Zintel] 1403—ab; [Jeffers & others] *1502
SYMPATHETIC: See Nervous System, Sympathetic
SYMPATHICOGONIOMA
clinical study, [Oberkircher] 1050—ab
metastatic, 990
of adrenal medulla, Turkey, 1471
SYMPOSIUM: See American Medical Association, Section on ....
SYNCOPE
after-cough fainting in asthma, [Derbes] 762—ab
SYNOVECTOMY
in tuberculosis of joints, [Wilkinson] 1220—ab
SYPHILIS: See also Venereal Disease; under specific organ or disease affected
Cerebrospinal: See Neurosyphilis
complications: aortic valve insufficiency, [Webster] 513—ab
complications: rupture of aortic aneurysm into esophagus, [Calenda & Urichio] *548; [Baer] 1571—C
complications: rupture of thoracic aneurysm into stomach, [Renner & Sindelar] *102
Diagnosis: See Syphilis, serodiagnosis
in Afghanistan, Turkey, 163
serodiagnosis, agglutination of Treponema pallidum in serums, [McLeod] 761—ab
serodiagnosis, standardization of tests, Norway, 663
serodiagnosis, tests for reagin after treating neurosyphilis, [Thomas] *718
serodiagnosis, tests in pregnant women, Norway, 875
treatment, early, with procaine penicillin in oil (PAM), [Thomas] 678—ab

SYPHILOLOGY
American Academy of, meeting in Chicago, 1188
American Board of: See American Board
SYRACUSE UNIVERSITY
new special education building, (photo) 865
SYRINGE
glass urethral, removing permanganate stains from, 258; (replies: use oxalic acid) [Palmer; Evans] 894

SOCIETIES AND OTHER ORGANIZATIONS

Acad.—Academy *Indust.—Industrial*
Am.—American *Inst.—Institute*
A.—Association *Internat.—International*
Coll.—College *M.—Medical*
Commn.—Commission *Med.—Medicine*
Comm.—Committee *Nat.—National*
Conf.—Conference *Pharm.—Pharmaceutical*
Cong.—Congress *Phys.—Physicians*
Dist.—District *Soc.—Society*
Div.—Division *Surg.—Surgery*
Found.—Foundation *Surgs.—Surgeons*
Hosp.—Hospital *S.—Surgical*

Academic Press, Inc., 1187
Acoustical Materials A., 572
Soc. of America, 572
Aero M. A., 225
Alabama Crippled Children's Rehabilitation Service, 153
M. A., 1025
Pharm. A., 1025
Alameda-Contra Costa M. A., 568
Alaska Board of Health, 1186, 1558
Territorial M. A., 1186
Albany County (N. Y.) Department of Public Welfare, 963
Allegheny County (Pa.) M. Soc., 1291
All-Pakistan M. Conf., 1289
Alpha Epsilon Delta, 1559
Omega Alpha, 38
Omega Alpha, Boston University Chapter, 864
Alumni A. of Cornell University M. Coll., 735
Am. Acad. for Cerebral Palsy, 738, 1559
Acad. of Allergy, 1105
Acad. of Dermatology and Syphilology, 1188
Acad. of General Practice, 570, 1186
Acad. of General Practice Chapters: Connecticut, 495; Idaho, 1454; Washington, 738; West Virginia, 963
Acad. of Ophthalmology and Otolaryngology, 1372
Acad. of Orthopedic Surgs., 222, 572
Acad. of Pediatrics, 41, 223, 1371
Acad. of Psychosomatic Med., 866
Acad. of Tropical Med., 964
A. for the Advancement of Science, 1188; 1459, 1559
A. for the Surg. of Trauma, 439
A. of Blood Banks, 1293
A. of Hosp. Consultants, 1559
A. of M. Clinics, 157, 1105
A. of Obstetricians, Gynecologists, and Abdominal Surgs., 40, 652, 1459
A. of Public Health Phys., 573
Baptist Foreign Mission Soc., 37
Board of Anesthesiology, 1459
Board of Dermatology and Syphilology, 1459
Board of Otolaryngology, 439
Cancer Soc., 153, 220, 223, 436, 439, 498, 867
Cancer Soc. Divs.: Indiana, 496; Kansas, 221, 1184; Michigan, 649; Pennsylvania, 496; Wisconsin, 437, 738
Coll. of Allergists, 1105
Coll. of Cardiology, 964
Coll. of Chest Phys., 1105
Coll. of Chest Phys. Chapters: Illinois, 435, 1368; Kansas, 153; New Jersey, 1103
Coll. of Phys., 963
Coll. of Surgs., 224, 499, 737
Coll. of Surgs. Chapters: Idaho, 220; New Jersey, 436
Cong. of Physical Med. and Rehabilitation, 572
Dental A., 1289
Diabetes A., 651, 963
Education Found., 1457
Federation of Clinical Research, Western Section, 963
Found. for Allergic Diseases, 1105
Fracture A., 571
Fur Company, 735
Gastroenterological A., 650, 651
Goiter A., 1187
Heart A., 156, 223, 1185, 1188, 1456
Indust. Hygiene A., 572
Inst. of Architects, 572
Inst. of Electrical Engineers, 1027
Inst. of Nutrition, 1187, 1292
Korean Found., 1184
Legion Auxiliary, 1455
Leprosy Missions, Inc., 156
M. A., 223, 572, 1105, 1188, 1368, 1458, 1559
M. A. Council on M. Education and Hosps., 1183
M. Women's A., 1104
M. Writers' A., 1187, 1289
Mutual Security Agency, 41
Occupational Therapy A., 964
Orthopedic A., 222
Otorhinologic Plastic Surg. Soc., Inc., 497
Psychiatric A., 39, 437, 651, 1559
Psychosomatic Soc., 1187
Public Health A., 573, 964, 965, 1371
Public Welfare A., 1188
Red Cross, 1106
Rheumatism A., 963
Roentgen Ray Soc., 39, 1456
School Health A., 964, 1368
Soc. for the Study of Arteriosclerosis, 866, 1293
Soc. for the Study of Sterility, 497, 866
Soc. of Anesthesiologists, 499, 1371
Soc. of Clinical Pathologists, 572
Soc. of Planning Officials, 572
Soc. of Plastic and Reconstructive Surg., 1454
Soc. of Safety Engineers, 572
Soc. of Tropical Med. and Hygiene, 964
Topical A., 222
Trudeau Soc., 572, 1371
Urological A., 1289
Urological A., North Central Section, 498
Arkansas Acad. of General Practice, 568
M., Dental and Pharm. Soc., 568
M. Soc., 568, 1558
Obstetrical and Gynecological Soc., 1454
Armour Research Found. of Illinois Inst. of Technology, 569, 572
Arthritis and Rheumatism Found., 39
and Rheumatism Found., Eastern Pennsylvania Chapter, 866
A. for Research in Nervous and Mental Disease, 1292
for the Aid of Crippled Children, 1290
of Am. M. Colls., 652, 738, 1291, 1558
of Am. Phys. and Surgs., 498
of Ex-Resident and Resident Phys. of the Philadelphia General Hosp., 1104
of Life Insurance M. Directors, 438
of M. Illustrators, 223
of Military Surgs. of the United States, 964, 1459
of Reformed Presbyterian Missions, 1457
of State and Territorial Health Officers, 573
Atomic Energy Comm., 38, 437, 497, 1104
Auglaize County (Ohio) M. Soc., 1457
Baltimore City M. Soc., 864, 1369
Baltimore-Washington Dermatological Soc., 1293
Bankers Life and Casualty Company (Chicago), 1105
Batesville (Ind.) Board of Health, 495
Beth David Hosp. Alumni A., 1185
Borden Company Found., 1292
British Empire Cancer Campaign, 439
M. A., 1105
Orthopedic A., 572
Post-Graduate M. Federation, 1370
Buffalo Philharmonic Orchestra Soc., 496
Bunts, Frank E., Educational Inst., 155
Bureau of Vital Statistics, 1371
California Acad. of General Practice, 734, 1288, 1556
Cancer Commn., 1288
Soc. of Internal Med., 1556
Soc. of Ophthalmologists, 1288
Southern, Psychiatric Soc., 962
Canada, Health League of, 225
Cancer Conf. for Phys. (Rhode Island), 1186
Capital Dist. Conf. on Aging, 963
Carbon Dioxide Research A., 572
Carlinville (Ill.) Department of Health, 36
Caruthersville (Mo.) Rotary Club, 569
Central Outdoor Advertising Company, 650
Soc. for Clinical Research, 738
States Soc. of Indust. Med. and Surg., 439
Cerebral Palsy In. (Los Angeles), 648
Chicago Civil Service Commn., 1026
Dermatological Soc., 1557
Educational Television A., 1460
Gynecological Soc., 1103
Heart A., 1026, 1368
Inst. of Med. of, 864, 1557
M. Soc., 962, 1025
M. Soc., North Side Branch, 221, 864, 1184
Phys. Philharmonic Soc. of, 1103
Soc. of Anesthesiologists, 495
Soc. of Indust. Med. and Surg., 734
S. Soc., 495
Christ Hosp. Inst. of M. Research, 1291
Cincinnati, Acad. of Med. of, 650, 963
Greater, Safety Conf., 1026
Otolaryngologic Soc., 650
Cleveland Area Heart Soc., 650
City Health Department, 963
Clinic Found., 155
Diabetes Soc., 963
Greater, Diabetes League of, 963
Coll. of Am. Pathologists, 498, 572, 1292
of Am. Pathologists Regions: North Central, 866; Southwestern, 1288
Colorado State Department of Public Health, 1556
State M. Soc., 220, 962, 1556
Comm. on Internat. Exchange of Persons, 438
Community Council of Greater Little Rock (Ark.), 568
Conf. Board of Associated Research Councils, 438
of State and Provincial Public Health Laboratory Directors, 1459
on Connective Tissues, 1459
on Crippled Children (Va.), 437
Cong. of Indust. Health, 1369
of Neurological Surgs., 964
Connecticut Commn. on Alcoholism, 1558
Rheumatism Soc., 1454
Safety Soc., 1288
State Bar A. of, 1102
State Department of Health, 220
State M. Soc., 220, 1102
Council for Internat. Organizations in the M. Sciences, 571
Craig, William Riney, and Brown, Clyde Hulee, Memorial Fund, 1371
Crippled Children's Soc. (Fla.), 1102
Cuba, Liga Contra la Ceguera of, 1558
Dade County (Fla.) M. A., 1102
Dane County (Wis.) M. Soc., 866
Davenoprt (Iowa) Newspapers Inc., 1556
Delaware Acad. of General Practice, 1288
M. Soc. of, 495, 1288
Denver County M. Soc., 36
Detroit Acad. of Orthopedic Surg., 37
de Villiers, Robert Roesler, Found., 1290
Disabled Am. Veterans, 1025
District of Columbia, M. Soc. of the, 1183
Doheny, Estelle, Eye Found., 864
Douglass, Fred Melvin, Found., 1457
Dubuque County (Iowa) Dental Soc., 1289
County (Iowa) M. Soc., 1289
Duke M. Alumni A., 650
Dumas (Ark.) Lions Club, 568
Durham (N. C.) Life Insurance Company, 222
Dutchess County (N. Y.) M. Soc., 963
Edgar County (Ill.) M. Soc., 1556
Edinburgh, Royal Coll. of Phys. of, 1183
Electro-M. Manufacturers A., 1187
Erie County (N. Y.) M. Soc., 496
Essex County (N. J.) M. Soc., 1289
County (N. J.) Pathological and Anatomical Soc., 1289
Federal Communications Commn., 1187
Florida Crippled Children's Commn., 1102
M. A., 40, 648
Obstetric and Gynecologic Soc., 1183
Pediatric Soc., 1288
Soc. of Ophthalmology and Otolaryngology, 1288
Ford, Chandler, Found., 1026
Found. Fund for Adult Education, 1459
Fort Steuben (Ohio) Acad. of Med., 963, 1291
France, Acad. of Surg. of, 1457
French Cong. of Med., 41
Cong. of Otorhinolaryngology, 41
Cong. of Surg., 1457
Georgia Heart A., 1183
M. A. of, 1102
German Inst. for Pharmacology, 41
Neurological Cong., 221
Governor's Comm. for Employment of the Physically Handicapped, 1025
Conf. on Exceptional Children, 220
Great Britain and Ireland, Pathologic Soc. of, 1370
Greene County (Mo.) M. Soc., 154
Gulf Coast Clinical Soc., 438
Coast Conf. on Indust. Health, 223
Hawaii Territorial Board of Health, 156, 1105
Health A. of Rochester and Monroe County (N. Y.), 1026
Hektoen Inst. for M. Research, 1289, 1556
Hennepin County (Minn.) M. Soc., 439
Holt Radium Inst. of Manchester, England, 153
House Officers' A. of New England Center Hosp., 735, 1184
Houston (Tex.) Chamber of Commerce, 223
Idaho Inst. of Christian Education, 1454
Southwest. Dist. M. Soc., 220
State M. A., 36
Illinois Acad. of General Practice, 568
Board of Public Welfare Commissioners, 1103
Commn. for Handicapped Children, 220
Soc. of Anesthesiologists, 495
State Department of Agriculture, 1183
State M. Soc., 153, 962
Trucking Industry, 1368
India, A. of Pediatricians of, 1559
Indiana Acad. of Ophthalmology and Otolaryngology, 495
Indust. Hygiene Found., 1027
Inst. for Juvenile Research, 1368
for M. Research (Cedars of Lebanon Hosp.), 1370
of Cytology (Beth-El Hosp., Brooklyn), 1184
of Indust. Health (University of Michigan), 650
of Ophthalmology (Columbia-Presbyterian M. Center), 569
of Physical Med. and Rehabilitation Groups: N. Y. University, 1104; Peoria, Ill., 1025
of Radio Engineers, 1027
Instituto de Puericultura (Rio de Janeiro), 1368
Instrument Soc. of America, 1027
Internat. Anesthesia Research Soc., 157
Blood Transfusion Soc., 41
Cancer Cong., 153, 1027, 1292
Cardiological Cong., 1027
Coll. of Surgs., 1027, 1106, 1289
Coll. of Surgs., Haitian Chapter, 1293
Coll. of Surgs., U. S. and Canadian Sections, 40
Conf. of Doctors in Alcoholics Anonymous, 1187
Conf. on Low Temperatures, 1459
Cong. of Hydrotherapy and Thalassotherapy, 1189

V 15
1953

Societies and Other Organizations—Continued
Cong. of Pediatrics, 41
Cong. of Radiobiology, 153
Cong. of Radiology, 41
Cong. on Medicinal and Similar Plants, 1027
Cong. on Oto-Neuro-Ophthalmology, 1027
Council of Scientific Unions, 571
Labor Office, 1185
Neurological Cong., 221
Physiological Cong., 497, 571
Soc. for Speech and Voice Science, 1185
Soc. of Orthopaedic Surg. and Traumatology, 1559
Soc. of Surg., 1457
Union Against Cancer, 1292
Union for Health Education of the Public, 1368
Union of Physiological Sciences, 498, 571
Inter-Soc. Cytology Council, 155
Iowa Pediatric Soc., 153
State Board of Health, 36
State Dental Soc., 1289
State Department of Health, 153, 221
State M. Soc., 36
Italian Soc. for Rheumatology, 1187, 1372
Jersey City (N. J.) M. Center Alumni A., 1026
Jones, Dr. Everett O., Scholarship Fund, 1458
Juneau (Alaska) Mental Health A., 1558
Kansas League of Nursing, 1184
M. Soc., 221, 735
State Board of Health, 153, 221, 735, 1184
Kellogg, W. K., Found., 37, 435, 1458
Kentland-Jefferson (Ind.) Consolidated School Board, 486
Kentucky Acad. of General Practice, 37
Conf. on Handicapped Children, 649
Coordinating Council for the Study of Handicapped Children, 649
Rural M. Scholarship Fund, 435
State Department of Health, 37
State M. A., 37, 221, 435, 1368
Kessler Inst. for Rehabilitation, 496, 736
Kings, County of, M. Soc. of the, and Acad. of Med. of Brooklyn, 569, 1026
Land Clearance Comm., 1556
La Presse Médicale, 1293
Lasdon Found., Inc., 651
Lasker, Albert and Mary, Found., 1188
Lawrence County (Ohio) M. Soc., 1457
League of Virginia Counties, 1105
Levinson, Julian D., Research Found., 1027
Liberty Life Insurance Company (Greenville, S. C.), 737
Life Insurance M. Research Fund, 651
London, Inst. of Orthopaedics of, 1370
Los Angeles City Health Comm., 1025
County Heart A., 648
County M. A., 568
Louisiana, Radiological Soc. of, 1454
Louisville Times Found., 435
Luzerne County (Pa.) M. Soc., 155
Macy, Josiah Jr., Found., 1459
Maine Acad. of General Practice, 1455
M. A., 735
State Department of Health and Welfare, 649, 735
State of, Legislative Research Comm. of the, 649
Malvern (Pa.) Inst. for Alcoholism and Psychiatric Studies, 1288
Marion County (Ind.) Tuberculosis A., 496
Markle, John and Mary R., Found., 571
Maryland Acad. of General Practice, 649, 864
State of, M. and Chirurgical Faculty of the, 864, 1455
Massachusetts M. Soc., 1455
Soc. of Anesthesiologists, 571
Soc. of Examining Phys., 1026
Mayerstein Inst. of Radiotherapy (London), 153
Mead Johnson & Company, 1371
M. Cong. of French-Speaking Countries, 1293
Medico-Legal Soc. (Johannesburg, South Africa), 1187
Memphis-Shelbey County (Tenn.) M. Soc., 1558
Metropolitan Life Insurance Company, 569, 572, 652, 1187, 1291
Metropolitan-Washington Tuberculosis Conf., 1371
Miami, Greater, Heart A. of, 1102
Michigan Cancer Conf., 649
Department of Health, 649
Nutrition Council, 569
State M. Assistants Soc., 221
State M. Soc., 221, 649, 735, 1289
Mid-Continent Psychiatric A., 39, 1293
Midwestern Air Pollution Prevention A., 569
Milwaukee City Health Department, 1556
County, M. Soc. of, 1291
Oto-Ophthalmic Soc., 866
Minneapolis Chamber of Commerce, 439
Minnesota Acad. of Occupational Med., 439
Acad. of Occupational Med. and Surg., 1103
Heart A., 154
Indust. Nurses A., 439
Soc. of Clinical Pathologists, 866
Southern, M. A., 154
State M. A., 37, 439
United Nations A., 1184
Mississippi State M. A., 436
Valley M. Soc., 40, 1559
Mississippi Valley Trudeau Soc., 1293
Missouri Acad. of General Practice, 736
Heart A., 154
Montana M. A., 37, 1369
State Board of Health, 1369
Montgomery County (Md.) M. Soc., 1455
Montreal Clinical Soc., 740
Muscular Dystrophy Ass of America, Inc., 572
Dystrophy Ass of America, Chicago Chapter, 962
Museum of Science and Industry, 495
Nashville (Tenn.) Acad. of Med., 571
Nat. Acad. of Sciences, 1559
Advisory Cancer Council, 1186
Advisory Comm. to the Selective Service System, 1105
A. for Mental Health, 739
A. of Science Writers, 1188
Board of M. Examiners, 1558
Citizens Comm. for Educational Television, 1459
Conf. of Christians and Jews, 1183
Education A., 1368
Found. for Infantile Paralysis, 437, 438, 648
Freedoms Found., 1185
Gastroenterological A., 498, 1292
Heart Inst., 652, 1183
Inst. of Health, 738
Inst. of Neurological Diseases and Blindness, 155
M. A., 1292
Multiple Sclerosis Soc., 1105, 1292
Noise Abatement Council, 572
Office of Vital Statistics, 40, 157, 224, 438, 499, 573, 652, 739, 867
Research Council, 439, 498, 1106, 1559
Safety Cong. and Exposition, 652
Safety Council, 571, 652
Science Found., 1106, 1187
Soc. for Crippled Children and Adults, Inc., 437, 963
Soc. for the Prevention of Blindness, 1371
Tuberculosis A., 439
Nebraska State M. Soc., 735
Nemours Found., 437, 649
Neurological Inst. (Columbia-Presbyterian M. Center), 569
Neuropsychiatric Inst., 1290
Neurosurgical Soc. of America, 223, 1559
Nevada State M. A., 1456
New England Diabetes A., 1027
Postgraduate Assembly, 866
Soc. of Anesthesiologists, 571, 1293
New Hampshire Heart A., 38, 439
M. Soc., 439, 1456
Soc. of Anesthesiologists, 736
New Haven (Conn.) M. Soc., 1183
New Jersey Acad. of General Practice, 1289
Acad. of Med. of, 569, 1289
Allergy Soc., 569, 736
Gastroenterological Soc., 1103
M. Soc. of, 436, 1103
Neuropsychiatric A., 962
Neuropsychiatric Inst., 1456
Northern, Acad. of Med. of, 736, 962
Orthopaedic Soc., 1103
Soc. of Clinical Pathologists, 736, 1289
Soc. of Physical Med., 571
State Department of Health, 1289
State Soc. of M. Technologists, 736
New York Acad. of Med., 737, 865, 1290, 1370
Cancer Soc., 1185, 1558
City Department of Hosps., 1369
Diabetes A., 436
Heart A., 1456
Inst. of Clinical Oral Pathology, 1104, 1457
M. Soc. of the County of, 569
M. Soc. of the State of, 37, 736
Mental Health Comm., 1456
Soc. for Circulatory Diseases, 569, 1289
State Acad. of General Practice, 37, 736
State Department of Health, 37, 736, 1369, 1456, 1558
State Department of Mental Hygiene, 1456
State Psychiatric Inst., 1290
State Soc. of Anesthesiologists, 1290
Tuberculosis and Health A., 865
New Zealand Post-Graduate A., 155
North Carolina Orthopedic A., 650
Public Health A., 222, 1370
North Dakota Public Health A., 737
North Pacific Soc. of Internal Med., 156, 652
S. A., 1293
North Texas-Southern Oklahoma Fall Clinical Conf., 156
Northwest Soc. for Clinical Research, 963
Nutrition Found., Inc., 1187
Ohio Acad. of General Practice, 155
Archeological and Historical Soc., 436
Central, Heart A., 496
Northwestern, M. A., 570, 1457
Soc. of Anesthesiologists, 155
State M. A., 436, 737, 1457
State Safety Conf., 569
Tuberculosis and Health A., 570
University Alumni A., 734
Oklahoma Advisory Health Council, 650
M. Research Found., 1104
School Health Administrators' A., 650
Soc. of Anesthesiologists, 737
Soc. of Psychiatrists and Neurologists, 1370
State Health Department, 650
State M. A., 650, 1370
Onondaga County (N. Y.) M. Soc., 496, 1557
Orange County (N. Y.) Heart A., 436
Oregon Civil Defense Agency, 1185
Mental Health A. of, 437
Southern, M. Soc., 437
State Aerie of Eagles, 437
State Elks A., 570
State M. Soc., 570, 1185
Otolaryngologic Alumni A. of the University of Illinois, 1183
Pacific Northwest Trudeau Soc., 1459
Science A., 1027
Science Cong., 1025, 1027
Pan Am. Cong. of Gastroenterology, 1027
Sanitary Bureau, 740
Sanitary Organization, 1459
Parke, Davis & Company, 495
Passaic County (N. J.) M. Soc., 496
Pennsylvania Acad. of Physical Med. and Rehabilitation, 571
Commonwealth of, Department of Health of the, 737
M. Soc. of the State of, 38
Southeastern, Heart A. of, 737
Western, Heart A., 1291
Persian Gulf M. Soc., 1189
Peruvian Soc. for Pathology, 1371
Pfeiffer, Gustavus and Louise Research Found., 1558
Phi Delta Epsilon, 651, 962, 1557
Delta Epsilon, Beta Zeta Chapter, 222
Philadelphia Allergy Soc., 737
Beneficial Saving Fund of, 866
Coll. of Phys. of, 571, 866, 1186
County M. Soc., 737, 866
Department of Public Health, 222
Metabolic A., 1557
Philatelic Soc., 1289
Philippine Heart A., 1460
Philippines, Department of Health of the, 225, 569
Nat. Research Council of the, 1027
Pi Kappa Epsilon, 155
Picker, James, Found., 429
Planned Parenthood Federation of America, 1456
Portland (Ore.) Acad. of Med., 865
(Ore.) Disaster Relief and Civil Defense Organization, 1185
Pottawatomie County (Okla.) M. Soc., 1104
Presbyterian Hosp. A., 36
President's Comm. on the Employment of the Physically Handicapped, 1369
Public Health Cancer A. of America, 436, 965
Puerto Rico M. A., 1291
Radiation Research Soc., 1187
Radiological Soc. of North America, 735, 1292
Radium Inst. of the University of Paris, 153
Raleigh (N. C.) Acad. of Med., 570
Read Drug and Chemical Company, 864
Rensselaer County (N. Y.) Board of Health, 1184
Rhode Island M. Soc., 1186
Richmond County (Ga.) Board of Health, 220
Rico (Ga.) Civic Club, 435
Rochester (N. Y.) Acad. of Med., 736, 962, 1026 and Monroe County (N. Y.), Tuberculosis and Health A. of, 1456
(N. Y.) Regional Hosp. Council, 37
Rockefeller Found., 436, 439, 571
Rocky Mountain Harvard M. Alumni A., 734
Mountain M. Conf., 38
Rome Center of Rheumatology, 1372
Rowan-Davie Counties (N. C.) M. Soc., 1370
Royal Coll. of Surgs., 1370
Soc. of Med., 1370
Runyon, Damon, Memorial Fund for Cancer Research, 1106, 1292
St. Louis Diabetes A., 652
M. Soc., 1184
Ophthalmological Soc., 736
Pediatric Soc., 736
Soc. of Neurology and Psychiatry, 1289
S. Soc., 569
San Francisco Heart A., 734
Sangamon County (Ill.) M. Soc., 962
Saunders, W. B., Company, 220
Schering Corporation, 1104
Scott County (Iowa) M. Soc., 1556
Seattle S. Soc., 497
Seneca County (N. Y.) Health Department, 1185
Seventh Dist. (S. C.) M. Soc., 1458
Shayne, John T., Company, 568
Smith, Alfred E., Memorial Found., 1370
Soc. for Biological Research, 1027
for the Study of Addiction, 1559
of Am. Bacteriologists, 156
South Am. Cong. of Angiology, 1027
South Carolina Soc. of Anesthesiologists, 737
South Central Pennsylvania Jefferson Alumni A., 155
South Dakota Board of M. Examiners, 497
State M. A., 1105
Southeastern S. Cong., 37
Southern Electroencephalographic Soc., 739
M. A., 739
Southwestern M. A., 739
S. Cong., 224
Sparta (Wis.) Kiwanis Club, 1291
Special Libraries A., 1371
Stamford (Conn.) Heart A., 962
Standard Oil Company (N. J.), 1456
State University of Iowa Council on Children and Youth, 153
Syracuse (N. Y.) Acad. of Med., 496, 1557
Technical Cooperation Administration, 1184
Tennessee Acad. of General Practice, 571
Acad. of Ophthalmology and Otolaryngology, 571
Radiological Soc., 1458

Societies and Other Organizations—Continued
State M. A., 571, 1558
State Pediatric Soc., 571
Thoracic Soc., 571
Territorial A. of Plantation Phys. (Hawaii), 156
Texas Acad. of General Practice, 222
Acad. of Internal Med., 1186
M. A., 1291
Rheumatism A., 1186
Tillman County (Okla.) M. A., 1370
Trudeau, Edward L., Found., 498
Tulsa (Okla.) Acad. of General Practice, 1104
County (Okla.) M. Soc., 1458
United Cerebral Palsy, 223, 651, 734, 1027, 1559
Mine Workers Welfare and Retirement Fund, 438
Nations Assembly, 1184
U. S. Department of Defense, 737, 1103
Department of Health, Education, and Welfare, 154, 435, 1102, 1104, 1184, 1454
Department of State, 648, 1289
Information and Educational Service, 1289
Navy Department, 1457
Public Health Service, 1186, 1454, 1556, 1558
Vanadium Corporation, 36
Upper Midwest Indust. Health Conf., 439
Utah State M. A., 38
Vanderburgh County (Ind.) M. Soc., 495
Vermont A., for the Blind, 1458
Heart A., 38, 738
Heart Comm., 738
State Department of Social Welfare, 1458
State M. Soc., 439, 1371
Virginia Council on Health and M. Care, 437, 1105
Hospital A., 1105
M. Soc. of, 651, 1105
Soc. for Pathology and Laboratory Med., 651
State Health Department, 1105
State Welfare Department, 1105
Washington County (Ark.) Historical Soc., 1454
State Department of Health, 866, 1027
State Heart A., 734, 866
State M. A., 39, 497, 738, 1027
Wayne County (Mich.) M. Soc., 1289
Western Soc. for Clinical Research, 963
S. A., 1188
Tuberculosis Conf., 157
West Virginia Conf. of Tuberculosis Workers, 38
Heart A., 866, 1458
State M. A., 1105
State M. Licensing Board, 156
Trudeau Soc., 39, 1186
Tuberculosis and Health A., 39, 1186
Wexler, Harry, Endowment Fund, 1185
Winthrop-Stearns, Inc., 498
Wisconsin Anti-Tuberculosis A., 866
Council of Safety, 39
Diabetes A., 156
Manufacturers A., 39
Pharmacists Inst., 651
Soc. of Anesthesiologists, 438
State Board of Health, 39
State Board of M. Examiners, 738
State Dental Soc., 738
State M. Soc. of, 39, 437, 651, 738, 1291
State Nurses A., 39
Trudeau Soc., 866
Woman's Auxiliaries: Kentucky State M. A., 221; M. Soc. of the State of Pennsylvania, 38; New Hampshire M. Soc., 439; Vermont State M. Soc., 439
Women's Faculty Club of Northwestern University M. School, 568
World Health Organization, 225, 740, 965, 1459
Yellowstone Valley M. Soc., 37

T

T VITAMIN: See Vitamins T
TACE: See Chlorotrianisene
TB 1: See Amithiozone
TEPP: See Tetraethyl Pyrophosphate
TV: See Television
TARES DORSALIS
lightning pains of, 606
TAFT, ROBERT A.
cancer laboratory to memorialize, 1291
TAKA-DIASTASE
liquid, to relieve esophageal obstruction from Serutan, [Johnson 235—C
TALKING: See Speakers; Speech; Voice
TAMPONAGE
balloon, method to control bleeding esophageal varices, 1286—E
TAPEWORM INFECTION: See Teniasis
TAURINE
treatment of malaria, Brazil, 1195
TAX: See also Medicolegal Abstracts at end of letter M
income, and Woman's Auxiliary, (Bureau report) 838
income, Coughlin case; right to deduct for graduate work, (Bureau report) 837
privilege, imposed on physicians for using hospital, 829
TAY-Sachs Disease: See Idiocy, amaurotic
TEACHERS
fund for, by Markle Foundation, 571
TEACHING: See Education, Medical
TEARS: See Lacrimation
TECHNOLOGISTS
schools for, A.M.A. Section on, (report) 944; (inspection by A.M.A.) 945
schools for, essentials of acceptable schools, revised to Dec. 1953, 946
"TEEN-AGE": See Adolescence
TEETH: See also Dentifrices; Dentistry; Gums; Jaws
caries and fluorine, [Amies] 1323—ab
caries (experimental) and skim milk powders, [McClure] 174—ab
Caries, prevention by fluoridation of water: See Water supply
dental foreign bodies in lung and esophagus, 35—E
dermal sinuses of dental origin, [Gurdin] 594—ab
endemic dental fluorosis in Kenya, [Williamson] 1128—ab
hormonal regulation of dentition, [Baume] 768—ab
osteogenesis imperfecta with dentinogenesis imperfecta, [Toto] 247—ab
TELATUTEN
arterial extract in arteriosclerosis, [Schlavetti] 68—ab
TELEFAQUE: See Acid, Iodopanoic
TELEVISION
A.M.A. films, (new), 434; (Bureau report) 852
A.M.A. "March of Medicine" series, 494; (cancer research on 2nd telecast) 858
clinics (postgraduate), Utah, 1458
closed circuit TV program, Md., 864
color, professional broadcasters, 498
color, program at St. Louis Clinical Meeting, 813; 1100—E
course for parents, U. of Michigan, 649; 864; 1184
educational stations, report on, 1459
films, 824
portrayal of physicians on, A.M.A. resolutions on, 829
programs, Pa., 1186
shows, promotion of, (report) 831
TEMPERATURE: See also Cold; Heat
environmental, for patient with Raynaud's disease, 1141
Indoor: See Air conditioning
produced in bone by ultrasonic therapy, [Bender] 517—ab
TEMPERATURE, BODY: See also Fever
basal, charts in timing conception, [Tyler] *1354
of surgical patients with and without thromboembolism, [Peters] 1321—ab
TEMPOROMANDIBULAR JOINT: See Jaws
TENDONS
nodules in, of hand, 238
ruptured patellar, airplane control cable to repair, [Chandler] *1093
splint for treating mallet finger, [Spigelman] *1362
TENIASIS
hymenolepiasis nana in prison inmates, 47
hymenolepiasis: treatment with chloroquine, [Basnuevo] 974—C
TENSION: See Stress
TERMINOLOGY: See also "Words and Phrases" under Medicolegal Abstracts at end of letter M
A.M.A. Standard Nomenclature of Diseases and Operations, (report) 929
definition of a physician, Belgium, 660
distinction between graduate and postgraduate education, (Council report) 941
Hansenosis for leprosy, [Feldman] 1041—C
multiple screening defined, (Council report) *1042
use of term "atrium" for "auricle" by New York Heart Assn., [Hyman] 1304—C
variety of membership terms used by constituent societies, [Cargill & Tracy] *1179
TERRAMYCIN: See Oxytetracycline
TERRY LECTURE: See Lectures
TEST Tube Baby: See Impregnation, artificial
TESTES
cancer, [Kimbrough & Cook] *1436
Hormone: See also Androgens
hormone (steroid); x-hormone or "inhibin", [Bishop] *534
surgery, orchiectomy plus estrogens for prostate cancer, [Holder] 885—ab
surgery (radical), orchiectomy plus irradiation in testis cancer, [Kimbrough & Cook] *1436
undescended, in male pseudohermaphrodites, [Morris] 515—ab
TESTOSTERONE: See Androgens
TETANUS
antitoxin, perceptive deafness from preventive use, [Berger] 165—ab
immunization (active) against, [North] 984—ab
TETRACHLORETHANE
poisoning (acute), [Sherman] 886—ab
TETRAETHYLAMMONIUM CHLORIDE
coronary vasodilators evaluated, [Russek & others] *207
TETRAETHYL PYROPHOSPHATE (TEPP)
poisoning due to anticholinesterase, [Moseley] 1318—ab
treatment vs. octamethyl pyrophosphoramide in generalized myasthenia gravis, [Grob] *531
TETRAETHYLTHIURAMDISULFIDE (Antabuse): See Disulfiram
TEXAS
Memorial Library, (photo) 152
placement of physicians in, (Council article) *1473
THALAMIC SYNDROME, 1327
THALAMYD: See Phthalylsufacetamide
THEATER
Krim Theater in Detroit, "Is there a doctor in the house," 37
THEOPHYLLINE ETHYLENEDIAMINE: See Aminophylline
THERAPEUTICS: See also Blood Transfusion; Drugs; Roentgen Therapy; Ultrasonics; under names of specific diseases and substances
music as therapeutic modality, 219—E
Self-Medication: See Self-Medication
THERMOTHERAPY: See Diathermy
THIGH: See Hip
THIOSEMICARBAZONE: See also Amithiozone
treatment of tuberculosis, Turkey, 1471
THORACOTOMY: See Thorax surgery
THORAX: See also Hemothorax; Pneumothorax; Pneumothorax, Artificial; Ribs
anomalies: funnel chest; indications and time for operation, [Bill] 520—ab
chest pain from exposure to soil dust in farmers, [Williamson] 164—C
chest x-rays, mass radiography surveys, Sweden, 1198
chest x-rays, outcome in survey detected tuberculosis [Ames] 588—ab
chest x-rays supraclavicular shadows in films, [Amory] 761—ab
chest x-rays, use in rabbits to evaluate therapeutic agents, [Steenken] 589—ab
Intrathoracic meningocele, [Baker] 66—ab
surgery, emergency thoracotomy in spontaneous hemothorax, [Borrie] 764—ab
THORIUM
dioxide (thorotrast), accidental visualization months after intracranial injection, [Leader] 65—ab
X treatment of Bechterew's disease, [Erlacher] 1594—ab
X, treatment of hemangiomatous nevi, [Wallace] 1058—ab
THORN TEST
in postoperative patients, [Grassi] 985—ab
THOROTRAST: See Thorium dioxide
THROAT: See Larynx; Neck; Otorhinolaryngology; Pharynx; Tonsils
THROMBIN: See also Blood prothrombin
human, source of homologous serum hepatitis outbreak, [Porter & others] *17
treatment for acute gastric hemorrhage with Topostasin [Uster] 1061—ab
U. S. P., N. N. R., (Upjohn) 1175
THROMBOCYTES: See Blood platelets
THROMBOCYTOPENIA: See Purpura, thrombopenic
THROMBOEMBOLISM: See Thrombosis
THROMBOPHLEBITIS: See also Phlebitis
diagnosis: differences in calf circumference, [Damon & McFarland] *622
of intercostal vein, fatal use of efocaine, [Angerer & others] *550
THROMBOSIS: See also Embolism; Thrombophlebitis
arterial, International Congress on, Paris, 876
arterial, of extremities, Paris, 877
cerebral, stellate ganglion block of value in stroke? [Ruben & Mayer] *1602
Coronary: See also Myocardium, Infarction
coronary acute, and artificial hibernation, Paris, 877
coronary, anticoagulants in, Paris, 876
coronary, long-term bishydroxycoumarin therapy, [Lund] 602—ab
coronary, pathogenesis of constrictive pericardium, [Moschcowitz] *194
mesenteric vascular occlusion, [Karn] 1490—ab
postoperative thromboembolism, bishydroxycoumarin prevents, [Milch] 1204—ab
postoperative thromboembolism, temperature and pulse in, [Peters] 1321—ab
prothrombin-proconvertin determination in thromboembolism with Owren's method, [Lund] 602—ab; 662; 876
pulmonary, and unexpected death in childhood, [Emery] 885—ab
thromboembolic disease in patients with mitral involvement, [Raynaud] 176—ab
treatment of thromboembolism with long-term bishydroxycoumarin, [Lund] 602—ab
venous, heparin for, [Artz] 1048—ab
venous, in arms, syndromes due to, International College discusses, Italy, 582
THRUSH: See Monilia
THUDICHUM psychiatric research laboratory, dedicated, Ill., 568
THYMECTOMY: See Thymus excision
THYMOL
treatment plus tetracycline in trichomoniasis vaginalis, [Candiani] 1131—ab
THYMOMA
malignant, in myasthenia gravis, [Katz] 520—ab

V 15
1953

THYMUS
excision and irradiation for myasthenia gravis, [Grob] *529
excision in myasthenia gravis, [Schwab & Leland] *1270
THYROID: See also Goiter; Goiter, Toxic
adenolipomatosis of: new type of goiter, [Chesky] 521—ab
cancer, failures and false localizations in tracer technique, [Corrigan] 451—ab
cancer in twins, 608
cancer, prognosis, role of age, [Crile] 679—ab
cancer, radioactive iodine for, [Rawson] 1203—ab; [Meckstroth] 1205—ab
desiccated, for prostate cancer, [Bornmann] 1059—ab
disease, American Goiter Association's merit award, 1187
disease, lecture on, 740
Excision: See Thyroidectomy
Extract: See also Thyroxin
extract, effect on low basal metabolism rates in elderly, [Kountz] *781
extract in hypertension, [Bradlow] 1593—ab
extract, use in Adams Stokes syndrome, 776
function, early effects of radioiodine, [Myant] 1487—ab
function of males vs. females in relation to age, [Kountz] *779
Hyperthyroidism: See Hyperthyroidism
Hypothyroidism: See Hypothyroidism
Inflammation: See Thyroiditis
menstrual cycle in baboon in relation to, [Gilman] 1322—ab
neuromuscular disease relation to, [Millikan] 585—ab
tired and nervous patients, 991
THYROIDECTOMY
indications for, in possible hyperthyroidism, 1598
myxedema heart secondary to, [Weyher] *639
subtotal, follow-up in toxic goiter, [Dolerup] 1324—ab
THYROIDITIS
acute, [Sampalo] 687—ab
THYROTOXICOSIS: See Goiter, Toxic
THYROXIN
therapy of prostate cancer, [Bornmann] 1059—ab
TIC
convulsive: Gilles de la Tourette's disease (reply) [Yap] 528
TILES
asphalt tile for gymnasium floors and walls, 893
conductive flooring for operating rooms to guard against explosions, 608
TINEA
capitis, [Robinson] 1482—ab
capitis, paint scalp with Carbo-fung for, [Henricke] 1380—C
TINNITUS
from quinine water, [Yohalem] 1304—C
TIREDNESS: See Fatigue
TISSUES: See also Cells; Epithelium; Skin; under names of specific organs
resistance to injury and hydrocortisone, [Nettleship] 1040—C
sections, time necessary for examination, 257; (replies) [Wright; Pickard] 1328
TOAD Test: See Pregnancy diagnosis
TOCOPHEROL: See Vitamins E
TOBACCO
cigaret smoking, increase of bronchial cancer, [Denk] 596—ab
smoking, effect on electrocardiograms and ballistocardiograms, [Davis] 1478—ab
smoking of one cigarette neutralizes 25 mg. of ascorbic acid in body, 527
TODAY'S HEALTH: See American Medical Association
TOES
hallux valgus, London, 972
TOLAZOLINE HYDROCHLORIDE (Benzazoline) Priscoline)
coronary vasodilators evaluated, [Russek & others] *207
therapy in aged, [Levy] *1260
TOLEDO
plan, civil defense director looks at the medical problem, [More] *1067
TOLSEROL: See Mephenesin
TOLUENE
time required for examination of tissue sections, (replies) [Pickard] 1328
TOLULEXIN: See Mephenesin
TONGUE
burning sensation, 1498
sublingual use of curare, [Neff] 1576—ab
TONSILLECTOMY
behavior changes in children subjected to, 493—E
endotracheal anesthesia for, in children, [Pender & Hallberg] *1073
poliomyelitis in relation to, [Hayes] 1481—ab; [Southcott] 1587—ab
poliomyelitis not reactivated 3 years later by, 456
simple device for tracheobronchial aspiration, [Emerson] *920
TONSILLITIS: See Tonsils, infected
TONSILS
Excision: See Tonsillectomy
Infected (acute follicular), carbomycin (magnamycin) for [Hewitt] 1053—ab
large, [Müller] 1218—ab
tuberculosis, [Stiefel] 1061—ab
TOOTH: See Teeth
TOOTHPASTES: Toothpowders: See Dentifrices
TOPECTOMY: See Brain surgery
TOPOSTASIN: See Thrombin
TORULOSIS: See Cryptococcosis
TOURIST CAMPS, HOSTELS, etc.
hostels for tuberculosis, London, 662
TOURISTS: See Travel
TOWNSEND RECOVERY PLAN
[Blasingame & Dickinson] *921
TOXEMIA
in Pregnancy: See Pregnancy
TOXIC Goiter: See Goiter, Toxic
TOXICOLOGY: See Poisoning; under names of specific substances
TOXIN: See also Streptococcus
in stored blood causing transfusion complications [Heilmeyer] 983—ab
TOXOPLASMOSIS
bovine, 565—ab
encephalitis in, [Weisse] 603—ab
from pet dogs, [Prior] 1204—ab
in adult, [Duke-Elder] 597—ab
in Colombia, 1036
Sabin-Feldman's dye test and complement fixation test [Roth] 1225—ab
6 types classified, especially congenital types, [Beckett] 1317—ab
TRACE ELEMENTS
supplement dairy ration to prevent brucellosis, (Council article) [Berman] *643
TRACER
technique, failures and false localizations in, [Corrigan] 451—ab
TRACHEA: See also Laryngotracheobronchitis
aspiration, simple device for, [Emerson] *920
TRACHEOTOMY
advantages; complications, [Davis & others] *1156
TRADE
Hazard; Poisoning etc.: See Industrial Diseases; Industrial Health; etc.
Unions: See Industrial Trade Unions
TRAFFIC Accidents: See Automobiles
TRAINING: See Education, Medical; Nurses and Nursing; Technologists
TRAINS: See Railroads
TRANSFUSION: See Blood Transfusion
TRANSISTOR Hearing Aid, (Council report) 491
TRANSLATIONS
center, established by National Science Foundation, 659
pool of Special Libraries Ass'n. and John Crerar Library, 1371
TRANSPLANTATION: See Grafts (cross reference)
of Skin: See Skin grafting
TRANSPORTATION: See Automobiles; Aviation; Travel
of Sick and Wounded: See Ambulances
TRANSPOSITION of the Great Vessels: See Heart anomalies
TRAUMA: See also Accidents; Burns; Disasters; Fevers; Wounds; under specific organs as Brain injuries
American Association for Surgery of, meeting, Oct. 1-3, 439
Athletic: See Athletics
due to Cold: See Frostbite
hyaluronidase in traumatic surgery, [MacAusland] 1314—ab
Industrial: See Industrial Accidents
injury, resistance to, hydrocortisone affects, [Nettleship] 1040—C
osteitis pubis of traumatic etiology, [Adams] 1314—ab
Parkinson's syndrome and, 1229
whiplash injuries of neck, [Schaefer] 974—C
TRAVEL: See also Transportation (cross reference)
cruise congress of International Congress of Hydrotherapy, 1189
expedition to South America; want to recruit young graduate, [Acworth] 235—C
physicians who visit Greece, [Mangun] 973—C
travelling atomic energy shows, 1458
TREADMILL
motorized, for quantitating intermittent claudication [Simon & Wright] *98; [Collens] 1115—C; (reply) [Simon & Wright] 1115—C
TREATIES
support needed for Bricker Amendment, 566—E; (Council report) 843
TREATMENT: See Therapeutics
TREPONEMA
pallidum agglutination in syphilitic serums, [McLeod] 761—ab
pallidum infection: See Syphilis
TRIALS: See Medical Jurisprudence
TRICHINOSIS
incidence in Vancouver area; examine human diaphragms, [Bourns] 598—ab
treatment, ACTH and cortisone, [Alvarez Borilla] 690—ab
TRICHLOROETHYLENE (Trilene)
anesthesia, 693; (replies) [Davis; Wilcox] 1416
TRICHOMONAS
vaginitis, thymol plus terramycin also estrogens for, [Candiani] 1131—ab
vaginitis, treatment, 775
TRICHOPHYTON tonsurans: See Tinea capitis
TRIDIONE: See Trimethadione
TRIHEXYPHENIDYL HYDROCHLORIDE (Artane)
name accepted by Council, 1447
TRILENE: See Trichloroethylene
TRIMETHADIONE (Tridione)
toxicity: nephrotic syndrome, [Wren & Nutt] *918
TRIPELENNAMINE HYDROCHLORIDE (Pyribenzamine)
to prevent penicillin reactions, (reply) [Roberts] 1498
TROMEXAN: See Ethyl Biscoumacetate
TROOPS: See Army, U. S.; Armed Forces; Medical Preparedness
TROPICAL DISEASE: See Leishmaniasis; Malaria; Schistosomiasis
TROPICAL MEDICINE
joint meeting on, 964
TROPICAL SPRUE: See Sprue
TROPICAL ULCER: See Leishmaniasis
TRUCK Drivers: See Automobiles
TRUMAN, HARRY S.
Commission: See President's Commission
TRUSTEES: See American Medical Association Board of Trustees
TRYPANOSOMIASIS
Chagas' disease, Argentina, 162
Chagas' disease in childhood, Brazil, 1195
Chagas' disease, xenodiagnostic test in campaign against, Chile, 1566
diagnosis, complement test (Kelser's), Colombia, 1037
TRYPSIN
aerosol, in bulbar poliomyelitis, [Varga] 1203—ab
TUAMINE: See Tuaminoheptane
TUAMINOHEPTANE SULFATE (Tuamine)
N.N.R. (Chemo Puro) 1175
TUBE: See Catheters
TUBERCLE BACILLUS
pretreatment with sulfuric acid to isolate [Weigand] 71—ab
tests acce to isoniazid, [Berg] 1593—ab
strains isolated, sensitivity to streptomycin [Bertoye] 689—ab
TUBERCULIN
test of duration of BCG allergy, Finland, 1377
TUBERCULOSIS: See also Tuberculosis of Lung; under names of specific diseases and organs, Medicolegal Abstracts at end of letter M
achievement awards, 1105
American Trudeau Society invites papers, 1371
biologic and epidemiologic aspects, 699—ab
case finding, outcome in survey-detected tuberculosis, [Ames] 588—ab
complications: leprosy; treatment, [Lima] 1490—ab
Control: See also Tuberculosis, immunization control, Paris, 748
etiology of sarcoid of Boeck, [Doepfmer] 686—ab
Grancher Foundation aims to isolate children from tuberculous parents, Paris, 49
Hospitals: See also Tuberculosis, sanatorium hospital (Philippine), testing with histoplasmin and coccidioidin, [Halde] 754—ab
hostels, London, 662
immunization, BCG, duration of, Finland, 1377
immunization, BCG, London, 1567
immunization: Petragnani's anatuberculin, Maragliano's, Dubra's or Salvioli vaccines, 1197; [DeToni] 1223—ab
immunization, Salvioli's diffusing vaccine, [Salvioli] 688—ab; 1197
in children, isoniazid for, [Boyd] 1585—ab
in children, streptomycin for, 5-year study, [McEnery] *627
in Scotland, 1567
in shoemakers, London, 233; [Stewart] 982—ab
International Congress of, in 1908, [Placak] *798
mortality rate falling, Denmark, 1112
pathogenesis of constrictive pericardium, [Moschcowitz] *194
patient employed in industry, Conn., 220
Prevention: See Tuberculosis, control; Tuberculosis, immunization
research fellowships by American Trudeau Society, 572
Sanatorium: See also Tuberculosis, hospitals
sanatorium (first) for ocular tuberculosis, London, 445
sanatorium, history of [Placak] *795
Swiss Association Against, convention, Italy, 1038
symposium on, Md., 1369
treatment, p-aminosalicylic acid, resistance to streptomycin after, [Turnbull] 251—ab
treatment, chemotherapy of miliary type [USPHS] 760—ab
treatment, 50 years ago, [Placak] *795
treatment, gamma globulin, [Lamarca] 767—ab

TUBERCULOSIS—Continued
treatment, isoniazid, Chile, 1036
treatment, isoniazid, development of resistance to [Berg] 1583—ab
treatment, isoniazid, effect on emotions, 1524—E
treatment, isoniazid, in children, [Boyd] 1585—ab
treatment, isoniazid, neurol toxicity, [Gammon] 676—ab
treatment, isoniazid, psychic disorders during, Paris, 48
treatment, isonicotinic hydrazides, drug resistant organisms during, [Coates] 593—ab
treatment, oxytetracycline, [Miller] 1579—ab
treatment, pneumoperitoneum, complications, [Rebrowitz] 590—ab
treatment, streptomycin, p-aminosalicylic acid, and isoniazid, Denmark, 1360; [Jensen] 1594—ab
treatment, streptomycin and dihydrostreptomycin compared, [Mahady] 754—ab
treatment, streptomycin and isoniazid, [Ritchie] 1223—ab
treatment, streptomycin and isoniazid, singly and combined, [Hobby] 240—ab
treatment, streptomycin, 5 year follow-up in VA hospitals, [Smith] 514—ab
treatment, streptomycin, in children, 5 year study, [McEnery] *827
treatment, thiosemicarbazone plus streptomycin and p-aminosalicylic acid, Turkey, 1471
treatment, trials in, bacteriological control, [Collard] 983—ab
treatment, use chest x-rays in rabbits to evaluate agents, [Steenken] 589—ab
Trudeau-Saranac consolidation, 498
Vaccine: See Tuberculosis, immunization
Western Conference, (first) 157
TUBERCULOSIS OF LUNG (pulmonary tuberculosis)
Case Finding: See Tuberculosis
complications: blastomycosis, [Stillians & Klempner] *560
complications: death after intercostal use of efocaine, [Angerer & others] *550
diagnosis, endobronchial method to increase bacilli in sputum, [Fourestier] 601—ab
epituberculous shadows, [Klinke] 1215—ab
roentgen localization of broncho-pulmonary segments by laminagraphy [Adler] 1047—ab
surgical treatment, effective operative collapse, relapse after, [Seip] 1408—ab
surgical treatment, isoniazid in lung excision, [Davidson] 247—ab
surgical treatment, lung resection for localized necrotic lesions, [Forsee] 1576—ab
treatment, artificial pneumothorax, effect of PAS and dihydrostreptomycin, [Birath] 1240—ab
treatment, chemotherapy, [Joiner] 983—ab
treatment, combined antibacterial medication, [Bernard] 254—ab
treatment, inadequate, of chronic type, [Ceres] 768—ab
treatment, isoniazid, [Cutler] 1575—ab
treatment, isoniazid, bacterial resistance in, [Medical Research Council] 1059—ab
treatment, isoniazid, "recent lesion" factor, [Bernard] 70—ab
treatment, pneumoperitoneum, Turkey, 972
treatment, pneumothorax-pneumoperitoneum? [Healy] 1486—ab
treatment, pyrazol derivatives, [Pestel] 689—ab
treatment, 6 agents compared, [Tempel] 589—ab
treatment, streptomycin and dihydrostreptomycin, [Cohen] 754—ab
treatment, streptomycin, roentgen study of lesions, [Dubarry] 1060—ab
treatment, "swing therapy" with PAS, streptomycin and isoniazid, [Tanner] 1407—ab
TUITION Fees: See Schools, Medical
TUMORS: See also under names of specific organs and types of tumors
Chromaffin Cell: See Pheochromocytoma
clinic, N. Y., 650; 1626; 1369
diagnosis, absolute eosinophil count in, [Murray] 63—ab
diagnosis, extemporaneous cytodiagnosis, [Castelain] 1226—ab
free cell, and Yoshida sarcoma, Japan, 47
in dogs, fed o-aminoazotoluene or p-dimethylaminoazobenzene, [Nelson] 170—ab
in identical twins, surgical significance [Lee] 1412—ab
in rats injected with carcinogenic quinones from beetles, [Spies] *189; *190
Malignant: See also Cancer; Sarcoma
malignant, hypophysectomy in [Luft] 171—ab
malignant, multiple neoplasms, [Arenas] 1590—ab
metastases, 81—ab
metastases, blood-borne, [Coman] 242—ab
Polypous: See Polyps
treatment, bilateral adrenalectomy [Barker] 1319—ab
Wilms': See Kidneys, tumors
TUNA Fish: See Fish
TURNER, E. L., appointed Secretary of A.M.A. Council, 946
TURNER'S SYNDROME
in female, [Jackson] 1217—ab
in male, [Sougin-Mibashan] 1217—ab
TURPENTINE
as eye irritants, 455
TWINS
Brodie, surgical separation in craniopagus, [Grossman & others] *201
hemolytic disease of newborn due to ABO incompatibility, [Dunn] 448—ab
Identical, allergy in, [Bowen] 61—ab
in double uterus; one twin born 56 days after other, [Williams] 599—ab
inguinal hernia involving ovary, tube and uterus, [Torres Oliver] 1216—ab
spasmodic urethism in one, [James] 1132—ab
thyroid cancer in, 608
transplacental transmission of Western equine encephalomyelitis, [Shinefield] 591—ab
tumors in identical twins, [Lee] 1412—ab
xiphopagus, separation; survival [Reitman & others] *1369
TWO-STEP Test (Master): See Heart Function
TYLOSIS
hyperkeratosis affecting hands and feet, [Dencer] 1058—ab
TYPHOID
epidemic traced to unusual cause: desiccated coconut, Australia, 162
problem, Ill., 864
radiologic study of terminal ileum in, Chile, 970
second attacks, [Marmion] 599—ab
TYPHUS
campaign against, Mexico, 1113
treatment, antibiotic, effect on rising antibody titer in, 775
TYVID: See Isoniazid

U

U FACTOR: See Blood
UMT: See Military, Universal military training
ULCERS: See also Abscess; Colitis, ulcerative; Decubitus; Peptic Ulcer; under specific organs and regions
Curling's, multiple, [Bothe] 1054—ab
Tropical: See Leishmaniasis
Varicose: See Varicose Veins
ULTRASONICS
therapy, temperatures produced in bone, [Bender] 517—ab
ULTRAVIOLET RAYS
treatment (prolonged) of facial acne, dangerous? 776
UMBILICAL SOUFFLE
loud fetal heart murmur, 991
UNDERGRADUATE Work: Students; etc.: See Education, Medical; Schools, Medical; Students; Students, Medical; University
UNDERNUTRITION: See Nutrition
UNDERSEA CRAFT: See Submarines
UNDULANT FEVER: See Brucellosis
UNIONS: See Industrial Trade Unions; Medical Defense Union
UNITED CEREBRAL PALSY Associations: See Paralysis, cerebral
UNITED MINE WORKERS OF AMERICA
Second Conference on Medical Care in Bituminous Coal Mine Areas, 1952
UNITED NATIONS
World Health Organization: See World Health Organization
UNITED STATES: See also American; Federal
Air Force: See Aviation, U. S. Air Force
A.M.A. resolution on executive order of president of, (report) 927
Armed Forces: See Armed Forces
Army: See Army, U. S.
Atomic Energy Commission: See Atomic Energy
Congress: Delaney House Committee on chemicals in food products, [Seevers] *1331
Congress: House Committee, statements before, (by Dr. McCormick) 151; 739; (by Dr. Wermer) 731
Congress, Legislation considered by: See Laws and legislation, federal
Constitution, "Bricker Amendment" to, 566—E; 843
Department of Defense: See Armed Forces
Department of Health, Education, and Welfare, (Council report) 843; (medical and health budget) 1033
Food and Drug Administration: See Food
government agencies, medical and health budgets of, 1033
government, A.M.A. Committee on Federal Medical Services, (report), 952
government medical services, consolidation of, Hoover Medical Task Force, 1298
Government Positions for Physicians: See Physicians, positions open
House Committee: See United States Congress
Laws and Legislation: See Laws and Legislation, federal
Navy: See Navy, U. S.
Pharmacopeia: See Medicolegal Abstracts at end of letter M
Public Health Service: See Health, U.S.P.H.S.
Veterans Administration: See Veterans Administration
UNIVERSAL Military Training: See Military
UNIVERSITY: See also Education, Medical; Schools, Medical; under names of specific universities as Hebrew University
Degrees: See Degrees
of British Columbia, (eligibility of 1954 graduates for internships) *132
of California (at Los Angeles), (eligibility of 1954 graduates for internships) *132
of Edinburgh, general practitioner schemes in operation at, 445
of Florida, (new medical schools) *133
of Glasgow, type of practice of graduates 25 years later, 972
of Illinois, toxicology service, 1025
of Kentucky, (new medical schools) *133
of Michigan, (television course for parents) 649; 864; 1184
of Mississippi, (eligibility of 1954 graduates for internships) *133
of Missouri, (new medical schools) *133
of North Carolina, (eligibility of 1954 graduates for internships) *132; (county society project) 1370
of Oklahoma, surgery course postponed, 1558
of Pennsylvania, (survey of 1,733 cases of brain tumors) [Grant] *22
of Puerto Rico, (eligibility of 1954 graduates for internships) *132
Premedical Work: See under Basic Sciences; Educational, Medical, premedical
scholastic record of 1952-1953 freshman class, *129
Students: See Students; Students, Medical
University of Southern California School of Medicine, (25th anniversary) 1288
URACHUS
patent, Chile, 1112
URANIUM
mines, hazard of work in, 692
UREA
clearance, renal function test, [Goldring] *1245
in Blood: See Blood
in renal insufficiency and gout, [Bolliger] 1582—ab
URETERS
lesions, gross urinary hemorrhage, [Lee & Davis] *782
surgery, spinal fluid diverted into ureter in hydrocephalus, [Matson] 1483—ab
URETHRA
lesions, gross urinary hemorrhage, [Lee & Davis] *782
management of vesicourethral dysfunction in women, [Carson] *1152
stricture, in women, [O'Brien & Mitchell] *1149
URETHRITIS
chronic, in women, [O'Brien & Mitchell] *1149; [Carson] *1153
URIC ACID
in renal insufficiency and gout, [Bolliger] 1582—ab
URINALYSIS: See Urine examination
URINARY SYSTEM: See also Bladder; Kidneys; Ureters; Urethra
hemorrhage: a symptom, not a disease, [Lee & Davis] *782
Infection, combined penicillin and streptomycin to prevent, [Strähuber] 1489—ab
infection due to "yeast-like, fungus organism," 1497
URINATION
Inducing: See Diuretics
URINE
Albumin in: See Albuminuria
Blood in: See Hematuria
changes in nephropathia epidemica, Norway, 1470
examination of 200 patients with urethritis or trigonitis, [O'Brien & Mitchell] *1151
Incontinence after radical retropubic prostatectomy for cancer, [Lattimer & others] *1347
Porphyrin in: See Porphyria
Protein in: See Albuminuria
retention in children, clinical management, [Powell] *1341
retention (postoperative), new cholinergic drugs for, [Weinstein & Roberts] *268
secretion, modern theory, [Smith] *1513
specific gravity as kidney function test, [Goldring] *1245
Sugar: See Diabetes Mellitus
UROLOGY
American Board of: See American Board
quandary: chronic prostatitis, [Ghormley] *915
UTAH
State Medical Ass'n., Dr. Castle speaks his mind on A.M.A. policy, 151
UTERUS: See also Oviducts; Placenta
Cancer: See UTERUS CANCER *following*
disorders, x-ray diagnosis, [Davids] 514—ab
double, twins in, [Williams] 599—ab
foreign bodies: intracervical and intrauterine devices, (Council report), 1285
Hemorrhage (Functional): See Menstruation Hydatidiform Mole: See Placenta tumors
inertia, calcium for, 1141
inguinal hernia involving, [Torres Oliver] 1216—ab
intrauterine perforation of Meckel's diverticulum, [Rosza] 240—ab
tuberculosis of cervix, International College discusses, Italy, 582
wide isthmus, habitual abortion caused by, [Swaab] 767—ab

V 1
195

UTERUS CANCER
diagnosis, cervical smears in, [Anderson] 680—ab
Irradiation treatment, [Maier] 255—ab
of cervix, surgical treatment, [Meigs] 168—ab
UVEITIS
endogenous, in children with band-shaped keratopathy and arthritis, [Davis] 1574—ab
granulomatous, toxoplasmosis in adult, [Duke-Elder] 597—ab

V

VA: See Veterans Administration
VACCINATION: See also Immunization; under names of specific diseases as Influenza; Smallpox
BCG: See Tuberculosis, immunization, BCG
certificate, new international, 1194
of child with eczema, (replies), [Baldridge; Little] 694
skentophylactic method, [Little] 694
VACCINE: See under names of specific diseases as Influenza; Rabies; Smallpox; Tuberculosis
Petragnani's Anatuberculin: See Tuberculosis, immunization
Strain 19: See Brucellosis
VACCINIA
of eyelids, aureomycin for, [King & Forrest] *831
virus and myxoma virus compared, [Farrant] 1057—ab
VAGAL BODY
tumor, [Birrell] 1320—ab
VAGINA
absence of, with left inguinal hernia, [Torres Oliver] 1216—ab
pH of, relation to conception, [Tyler] *1351
sexual physiology of, and pubococcygeus muscle, Kinsey report, [Kegel] 1305—C
VAGINITIS
Trichomonas: See Trichomonas
VAGOTOMY: See Nerves, vagotomy
VALSALVA MANEUVER
effect on circulation, [Ellisberg] 169—ab
VALVULOTOMY: See Mitral Valve
VAN METER Prize: See Prizes
VANDERBILT UNIVERSITY
anonymous gift to, Tenn., 155
VAPOR
lipoidol vaporization in bronchography, [Girard] 888—ab
VARICOSE VEINS
Ace Elastic Hose for Men, 1285
Esophageal: See Esophagus
treatment (ideal) [Nabatoff] 1041—C
treatment, sclerotherapy, contraindications, 1141
VARIDASE: See Streptokinase-Streptodornase
VARIOLA: See Smallpox
VAS DEFERENS
lack of deferent ducts, [Trabucco] 1061—ab
surgery, epididymovas anastomosis for sterility, [O'Conor] *532
VASCULAR: See Blood Vessels
VASOMOTOR SYSTEM
glyceryl trinitrate to study vasospasm, [Foley] 168—ab
VASOPRESSIN
Du Vigneaud postulated formula for, 1524—E
VASOSPASM: See Vasomotor System
VECTORCARDIOGRAPHY, 992
VEGETABLES: See under names of specific vegetables as Beans; Beets; Carrots; Peas
VEGETATIVE Nervous System: See Nervous System, Sympathetic
VEINS: See also Blood Vessels
Caval: See Vena Cava
hepatic, catherization to determine portal venous pressure, [Kronk] 1591—ab
Inflammation: See Phlebitis; Thrombophlebitis
Injection into: See Injections, Intravenous
intercostal, thrombophlebitis, fatal intercostal use of efocaine, [Angerer & others] *550
major, effects of ligation, [Palumbo] 1018—ab
obstruction in arms, syndromes from, International College discusses, Italy, 582
Portal: See Portal Vein
pulmonary, transposed, [Levinson] 976—ab
Roentgen Study: See Portal Vein
terminal nerve corpuscles in walls of, Italy, 1038
Varicose: See Varicose Veins
VENA CAVA
inferior, ligation in cardiovascular diseases, [Bracci] 452—ab
portacaval anastomosis for portal hypertension, [Ripstein] 1403—ab
portacaval shunt for bleeding esophageal varices, 1287—E
VENEREAL DISEASE: See also Lymphogranuloma, Venereal; Syphilis
clinics, Mc., 735
cutaneous, in Belgian Congo, Belgium, 873
VENOM: See Snakes
VENTILATION: See Air conditioning
VENTRICULAR FIBRILLATION
cardiac arrest and; experimental study, [Stewart] 586—ab
cardiac resuscitation from, [Wégria] 680—ab
VERALBA: See Protoveratrines A and B
VERATRUM
alkaloids, clinical studies on, [Meilman] *540
VERTEBRAE: See Atlas; Spine
VERTIGO: See also Syncope
aural, Ménière's syndrome, [Atkinson] 1120—ab; 1142; (correction) 1460
VESICATION: See Blister
VETERANS: See also American Legion
enrollment in medical and basic science schools, 1952-1953, *126
G. I. Bill: See G. I. Bill
hospital priority for war pensioners, 1378
hospitalization entitlement of, (Committee report) 836
Medical Care: See also Hospitals, veterans
medical care, (Council report) 952
medical care of those with non-service connected disabilities, review by A.M.A., 152
medical care, regional conferences on, sponsored by A.M.A., 961
20 million, in civilian life, 872
wheelchair homes for, 968
VETERANS ADMINISTRATION
Hospitals under control of: See Hospitals, veterans
medical and health budget, 1033
physicians wanted at Kerrville, Tex., 504
Residencies offered by: See Residents and Residencies
VETERINARIANS
brucellosis in, from strain 19 vaccine, [Spink & Thompson] *1162; 1176—E
VIBRATION
work with vibrating tools, 1327
de VILLIERS Foundation: See Foundations
VINYLAST
conductive flooring for operating rooms to guard against explosions, 608
VIRGINIA
aggressive approach, Conference on Physicians Placement Service Activities, (Council report) *1116; 1522—E
VIOMYCIN
treatment of pulmonary tuberculosis, compared with 5 other agents, [Tempel] 589—ab
VIRILISM: See also Hermaphroditism
diagnosis of hyperadrenocorticalism, Italy, 1168
VIRUS: See also Colds
Coxsackie: See Coxsackie Disease
Hepatitis: See Liver Inflammation
infections, international symposium on, Mich., 649
morphology of myxoma and vaccinia viruses compared, [Farrant] 1057—ab
Pneumonia: See Pneumonia, atypical primary
Vaccine: See Influenza
VISAMMIN: See Khellin
VISCERA: See also under names of specific organs
eosinophilia in childhood from visceral larva migrans, [Dent] 683—ab
VISCOSITY
of commercial contraceptives; Shedlovsky mobilometer measures (Council article) [Gamble] *1019
VISION: See also Eyes; Ophthalmology
blurred, causes of, 456
defective, in athletes, 892
Double: See Diplopia
Loss of: See Blindness
VISUAL INSTRUCTION: See Moving Pictures; Television
VITAL STATISTICS
Death Rate: See also Fetus deaths; Infants, mortality; Life expectancy; Maternity; under names of specific diseases
death rate, drama in, 1177—E
death rate of distinguished vs. undistinguished doctors, [Pownton] 1379—C
death rate, widows, 1501—ab
morbidity, 1177—E
morbidity, in India, [Bowers] *1169
morbidity seen in general practitioners records, England, 1469
of Denmark, 874
of Italy, 506
VITAMINS: See also Medicolegal Abstracts at end of letter M
deficiencies (mixed), basic formula for treating, [Spies] *193
supplement to improve nutrition of children, [Spies] *185
VITAMINS A
excessive, and congenital abnormalities, 1176—E
VITAMINS B COMPLEX: See also Acid, folic; Pellagra
B_1: See also Acid, nicotinic
B_1 combined with phosphorus in therapy, [Ronconi] 599—ab
B_2: See Riboflavin
B_6: See Pyridoxine
B_{12}: See Cyanocobalamin
B_{12} with Intrinsic Factor Concentrate: See Cyanocobalamin
VITAMINS C: See Acid, ascorbic
VITAMINS D: See also Rickets
preparations in fortified milks, Council statement, 645
VITAMINS E
climacteric syndrome and [Blatt] 237—ab
VITAMINS K: See Menadione
VITAMINS T (GOETSCH)
in care of newborn and premature infants, [Schmidt] 1585—ab
VITREOUS
hemorrhage of unknown origin, 692
VIVISECTION: See Animal Experimentation
VOCABULARY: See Terminology
VOCATIONAL GUIDANCE: See Counseling
VOCATIONAL REHABILITATION: See Rehabilitation
VOICE: See also Speech
periodic loss of, 606
VOLKER (William) Fund: See Foundations
VOLUNTEERS to Aid Research: See Research
VOMITING: See also Nausea
in Pregnancy: See Pregnancy
of Blood: See Hematemesis
treatment, new drug; compound 2601-A, [Friend & Cummins] *180

W

W.H.O.: See World Health Organization
WAGE EARNERS: See Industrial Health
WAGES
"equalization pay" for physicians in armed forces, 646—E; 841
internship stipends, (Council report) *278
Tax on: See Tax, income
WAITING ROOM: See Physicians, office
WALKING: See Claudication
test before decision on mitral commissurotomy, [Lehmann] 1406—ab
WAR: See also Medical Preparedness; Military Medicine
Atomic Bombs used in: See Atomic Energy
Bacteriologic or Biologic Warfare: See Biologic Warfare
Civilian Defense against: See Civilian Defense
futility of, [Trimble] *1143
Heroes: See Korean War, Heroes
medicine and history, [Fulton] *182
Preparedness for: See Civilian Defense; Medical Preparedness
Prisoners: See Korean War, Heroes
Veterans: See Veterans
WARD Burdick Award: See Prizes, Burdick
WARREN, EUGENE R., report on J. S. Schlimmer's fraudulent license, 647—E; 665—BI
WASHING: See Laundries
WASHINGTON
Office: See American Medical Association
WATER: See also Ice
cleanest and polluted water, [Stevenson] 515—ab
contaminated with Endamoeba histolytica; boil water for 15 minutes, 1142
fluoridation, London, 507
fluoridation of water, London, 507
fluorine and dental caries, [Ames] 1323—ab
Mineral: See Mineral Springs
odor of, in swimming pool, 178
pollution, contracts to abate, USPHS reports, 1194
pollution control, 161
softened: high sodium content, (reply), [Bowman] 694
supply, add chlorophenothane (DDT) to? 1598
supply, lead poisoning, England, 1197
tonic, quinine in, tinnitus from [Yohalem] 1304—C
WATERHOUSE-FRIDERICHSEN SYNDROME
treatment, arterenol (Nor-Epinephrine) [Weiner] 973—C; [Uhl] 1052—ab
WAX CRAYONS: See Crayons
WEATHER: See Meteorology
WEBER-CHRISTIAN DISEASE: See Panniculitis
WEIGHT: See Body Weight; Obesity
WELFARE: See Public Welfare
United States Department of Health, Education and Welfare: See United States
WELLCOME, Sir HENRY
centenary exhibition, London, 874
WELLCOME Medal: See Prizes
WERLHOF'S Disease: See Purpura, thrombopenic
WERMER, PAUL, statement on cancer before U. S. House committee, 731
WEST-HILLIARD test for cancer, 1229
WEST VIRGINIA UNIVERSITY
new medical school, *133
WESTERN STATES
compact of, for higher education, A.M.A. resolutions on compact of, 829
WETZEL GRID
analyses for 2 undernourished children, [Spies] *185
WHEAT: See Bread; Macaroni
WHEELCHAIR
homes for veterans, grants for, 968
WHIPLASH Injuries: See Neck
WHIPPLE'S TRIAD
[dePeyster] 1478—ab
WHITAKER and Baxter: See American Medical Association, National Education Campaign
WHITBY, LIONEL, remarks at World Conference on Medical Education, 192—E
WHITE BLOOD CELLS: See Leukocytes
WHITE HOUSE conference on highway safety, 1466
"WHITE PAPER": See National Health Service, England

WHOOPING COUGH
immunization, postinoculation poliomyelitis, London, 506
yeast fraction which protects against, [Parfentjev] 1581—ab
WIDOWHOOD, 1501—ab
WIGGINS, W. S., new associate secretary of A.M.A. Council, 1367
WILLIAMS Lecture: See Lectures
WILLIS, Circle of, Aneurysm of: See Aneurysm
WILMS' Tumor: See Kidneys, tumors
WILSON'S Disease: See Lenticular Nucleus
WILSON-Kimmelstiel Disease: See Kimmelstiel
WINE
blood alcohol concentration relation to the time of drinking wine, [Serlanni] 521—ab
WINROD, GERALD B.
associated with Koch cancer quack, 647—E; 669—BI
WIPRUD, THEODORE, District Society honors, D. C., 1183
WIRELESS: See Radio; Television
WOMAN'S AUXILIARY
annual conference, Nov. 18-20, 733
income taxes and, (Bureau report) 838
WOMEN: See also Marriage; Maternity; Menopause; Menstruation; Pregnancy
in Medicine: See Nurses and Nursing; Physicians, women; Students, Medical, women
Kinsey report on: See Kinsey report
widowhood, 1501—ab
WOOD
chromoblastomycosis source of, [Barwasser] *556
WOOKEY Operation: See Esophagus cancer
WORCHESTER Rating Scale: See Malamud-Sands
WORDS AND PHRASES: See Terminology; Medicolegal Abstracts at end of letter M
WORK: See Effort; Industrial Health
Pay for: See Wages
Therapeutic Use of: See Occupational Therapy
WORKING CONDITIONS: See Industrial Hygiene
WORKMEN: See Industrial Health
WORKMEN'S COMPENSATION: See also Industrial Accidents
survey of medical relations under, (Council report) 834
WORLD AFFAIRS
physician role in, [Trimble] *1143
WORLD CONFERENCE ON MEDICAL EDUCATION
London, August 22-29, 1953, *108; 492—E; (Council report) 942
WORLD HEALTH ORGANIZATION
Expert Committee report on brucellosis, 1176—E
physicians in world affairs, [Trimble] *1146
staff, Venezuelan health director to, 740
symposium on influenza, 855—E
WORLD MEDICAL ASSOCIATION
to meet in Rome in 1954, 961
World Conference Medical Education and, 492—E
WORLD WAR I (1914-1918)
medicine, warfare, and history, [Fulton] *482
WORLD WAR II (1939-1945)
American medical officer in Jena: book autographed by German professor, [Wartenberg] 1115—C
atomic bomb casualties of Nagasaki, [Shirabe] 1482—ab
atomic bombardment, cerebral injuries from, [Uchimura] 171—ab
atomic bombardment, effect on 100 Japanese children in utero, 218—E
Craig-Brown Memorial Fund, Tenn., 1370
McBrearty memorial flag, S. C., 1458
medical casualties in, 46
medicine, warfare, and history, [Fulton] *482
WOUNDED
Transport of: See Ambulances
WOUNDS: See also Accidents; Burns; Trauma; under names of specific organs
WOUNDS—Continued
clean, prophylactic use of antibiotics in, [Meleney & Johnson] *1254
healing, effect of chlorophyll, [Lan] 1571—C
operative, plastic dressings for, Sweden, 1569
Suture of: See Suture
WRIST
chromoblastomycosis, [Barwasser] *556
WRITERS
authorship, trends in, 1080—ab
WRITING: See Books; Book Reviews at end of letter B; Journals; Newspapers; Press
Contest: See Prizes

X

X-HORMONE
from testes, [Bishop] *534
X-RAYS: See Roentgen Rays
XENODIAGNOSIS: See Trypanosomiasis
XERODERMA: See Ichthyosis
XERODIOGRAPHY
award for work on, N. Y., 1456
XIPHOPAGUS TWINS
separation; survival, [Reitman & others] *1360

Y

YEAST
fraction, protects against infection, [Parfentjev] 1581—ab
outgrowth of yeast, relation to intestinal antisepsis, [Poth] *1518
YESHIVA UNIVERSITY
in New York City, Einstein medical school, *133; (photo) 1557
YOSHIDA sarcoma and free cell tumors, Japan, 47
YOUTH: See Adolescence

Z

ZINC
chloride powder, irritation from, 1141
ZONDEK-Aschheim Test: See Aschheim-Zondek Test
ZOSTER: See Herpes zoster

V 15
195

AUTHOR INDEX

In this Index are the names of the authors of articles which have appeared in THE JOURNAL, the names of those who have read papers before Societies as published in THE JOURNAL and those whose articles have been abstracted in the Current Medical Literature Department. The * preceding the page reference indicates that the article appeared in full in THE JOURNAL.

For subject index see page 1601.

A

Abelmann, W. H., 677
Abrahamson, R. H., 978
Abramson, A. S., *10
Aceto, G., 887
Acworth, B., 235
Adams, R. D., 1574
Adams, R. J., 1314
Adler, F. H., *1358
Adler, H., 1047
Adlersberg, D., 513
Aguirre, A., 1320
Akerovd, J. H., 882
von Albertini, A., 1491
Allen, A. W., 1207
Alman, R. W., *562
Alpers, B. J., 1052
Alvarez, Buylla, P., 690
Ames, W. R., 588
Amies, A. B. P., 1323
Amiotti, P. L., 1324
Amory, H. L., 761
Anderson, A. F., 600
Anderson, C. L., *695
Anderson, G. W., 1052
Anderson, K., 983
André-Balsaux, G., 1320
Andreu Urra, J., 1407
Angela, G. C., 766
Angerer, A. L., *550
Angrist, A., 1577
Antoni, N., 689
Antonini, R., 1218
Arenas, N., 1590
Arends, A., 1589
Argüello Pitt, L., 1130
Armstrong, E. L., 754
Armstrong, J. B., 985
Armstrong, S. H., Jr., *82
Arner, B., 1123
Arnold, A., 979
Artz, C. P., 1048
Ashton, N., 597
Atkinson, M. A., 1120
Aub, J. C., 242

B

Bacala, J. C., 246
Bacon, H. E., *1249
Badano, B. N., 70
Badioli, C., 1588
Baer, P., 1407
Baer, S., 1571
Baggenstoss, A. H., 238, 451
Bailey, C. P., 246, 756, 758, 980
Baird, V. C., 1210
Baker, H. W., 62
Baker, J. M., 66
Baldueci, D., 689
Ball, C. O. T., 239
Ballablo, C. B., 1491
Bang, H. O., 770
Banks, B. M., 450
Barber, M., 1323
Bargen, J. A., 881
Barker, N. W., 670
Barker, W. F., 1319
Barkham, P., 882
Barlow, M. B., 1132
Barnes, R., 1220
Barnum, A. S., 588
Barondess, J. A., *17
Barr, M. L., 65
Barsoum, G. S., 600
Barter, R. H., 248
Bartlett, M. K., 173
Barton, R. T., *1017, (correction) 1460
Bartorelli, C., 1321
Barwasser, N. C., *556
Bashe, W. J., Jr., *17
Basnuevo, J. G., 974
Bastenie, P. A., 1226
Basu, P., 1486
Battaglia, B., 1575
Bauer, W., 979
Baume, L. J., 768
Baxter, J. H., 882
Bayer, O., 1219, 1223, 1224
Bayles, T. B., 759
Baylin, G. J., *1159
Bayrd, E. D., *784
Beal, J. M., Jr., 1319
Bean, W. B., *214
Beattie, J. W., 1217
Beaulieu, M., 247
Beck, C. A., *1170
Beck, P., 754
Beck, L. F., 57
Beigelman, P. M., 759
Bell, J. C., 449
Beller, A. J., 252
Beller, M. L., 883
Benaron, H. B. W., 1206
Benchimol, A. B., 879
Bender, L. F., 517
Bennett, R. L., *79
Bennett, W. A., 166
Bentel, H., 601
Benthin, D., 1582
Berdet, H., 888
Berg, G., 1593
Berg, H., 885
Berger, M. D., 165
Berglund, E. M., 1478
Bergquist, K., 1129
Bergstrand, C. G., 767
Berman, D. T., *643
Berman, L., 1204
Bernard, E., 70, 254
Bertoye, A., 689
di Biagio, F., 1490
Biancalana, L., 253
Bierman, H. R., 60
Bietti, G., 56
Bigelow, N. H., 58
Bigelow, R. R., 242
Bigham, R. S., Jr., *262
Bigliardi, P., 1132
Bill, A. H., Jr., 520
Billings, C. E., *5
Birath, D. G., 1210
Bircher, J., 690
Birdsong, M., *1077
Birrell, J. H. W., 1223, 1320
Bisel, H. F., *712
Bishop, P. M. F., *534
Bjerglund, R., 770
Björk, V. O., 1315
Black, M. M., 684
Blacket, R. B., 1126
Blais, J. A., 979
Blasingame, F. J. L., *921
Blatt, M. H. G., 237
Blatt, N. H., 1574
Bledsoe, A., 59
Blount, S. G., Jr., *1081
Blumberg, N., *625
Blumgart, H. L., 239
Blunden, K. E., 1319
Boaro, G., 68
Bobrowitz, I. D., 590
Boden, E., 1223, 1224
Boeml, G., 689
Böyesen, S., 675
Boger, W. P., 512
Boles, R. S., Jr., *1505
Boling, L., 684
Bolliger, A., 1582
Bolton, H. E., 756, 980
Bonebrake, M., *630
Boone, G., *179
Bornmann, G., 1058
Borrie, J., 764
Bothe, F. A., 1054
Bothwell, T. H., 879, 1593
Bottaro, H. G., 1590
Bottini, E. B., 1061
Bourgeois-Cavardin, J., 1131
Bourns, T. K. R., 598
Bourrain, Y., 769
Bowen, O. R., 1570
Bowen, R., 61
Bowen, S. S., 1404
Bowers, D., 686
Bowers, J. Z., *1167
Bowley, C. C., 765
Bowman, H. W., *24
Boyadjian, N., 1126
Boyan, C. P., 1056
Boyce, F. F., 1312
Boyd, G., 755, 1585
Boyden, A. M., 763
le Bozec, J. M., 254, 254
Braeci, U., 432
Brackenridge, R. D. C., 67
Bradlow, B. A., 879, 1585
Bradshaw, R., *1077
Brady, L. W., 521
Bramstedt, F., 68
Brancadoro, G., 984
Braude, A. I., 585
Braun, P., 687
Braunwarth, K., 524
Brehme, T., 1060
Brem, H., 1132
Brick, I. B., 519
Brihaye-Van Geertruyden, M., 597
Briskier, A., 238
Bristol, L. J., 589
Brochier, M., 176
Brock, L. L., 519
Brodal, A., 675
Bromberg, Y., 516
Bronstein, L. H., 169
Brooke, B. N., 600
Brown, M., 1206
Bruce, K. W., 247
Bruce, R. A., 760
Brugsch, J., 771
Brun, J., 1490
Bryce-Smith, R., *1156
Buchthal, F., 986
Buckl, A. J., 1125
Buckwalter, F. H., 679
Bürkl, F., 985
Bull, G. M., 766
Bundesen, H. N., *166
Bunts, R. C., 1319
Burbank, B., 1575
Burge, F. W., 676
Burns, T. W., 979

C

Cabrera, E., 764
Cadlott, P., 1130
Cadman, E. F. B., 1221
Cadoret, M., 767
Caffey, J., *1333
Cahill, W. J., *211
Calenda, D. G., *548
Call, D. W., 977
Camain, R., 1131
Campbell, C. J., 512
Campbell, J. A., 1125
Candiani, G. B., 1131
Canelas, H. M., 1215
Cannizzaro, M., 521
Caprio, T. A., 70
Carl, E., 983
Carpetti, G., 1219
Carrain, G., 176
Carrera, G. M., 683
Carroll, F. D., 586
Carroll, W. H., *1018
Carson, M. J., 1212
Carson, R., *1152
Carter, A. B., 766
Carter, D. D., *1159
Carter, G. W., 51
Castelain, C., 1225
Castelain, G., 1225
Catalano, C., 1488
Cattell, R. B., 516
Cecchi, G., 984
Celoria, J. E., 70
Censi, G., 768
Cetrángolo, R., 1219
Chaffin, L., 586
Challenge, A., 1059
Chalmers, D. G., 983
Chamberlain, R. H., *488
Chance, D. P., *993
Chandler, F. A., *1093, 1314
Chapman, C. B., 1400
Charpy, J., 1408
Charr, R., 594
Chatterjea, J. B., 1486
Chávez, I., 764
Cheatham, W. J., 677
Cheek, J. H., 56
Cheever, F. S., 1199
Cheng, J. T. O., *211
Chesky, K., *1499
Chesky, V. E., 521
Chevallier, J., 1592
Chevallier, P., 769
Childs, P., 1403
Chivington, P. V., Jr., *1515
Christiansen, T., 769
Christopherson, W. M., 1480
Church, B. D., 756
Cimoch, P. J., *1004
Ciocatto, E., 1225
Clark, A. B., *787
Clark, D. H., 251
Clark, E. M., 598
Clark, W. S., 979
Claude, F., 253
Cleveland, D., 1579
Clifford, S. H., *473
Coates, E. O., Jr., 593
Cockburn, M. K., 600
Cogan, D. G., 1574
Cohen, H., 1221
Cohen, M. M., 1213
Cohen, S. G., 1211
Cohen, S. S., 754
Cohen, V. L., 61
Colby, F. H., 172
Colcock, B. P., 516
Cole, R. T., 591
Cole, C. R., 1203
Cole, H. N., *1515
Cole, H. N., Jr., *1515
Coley, B. L., 62
Collard, P., 983
Collens, W. S., 1115
Collier, H. S., 1480
Colodzin, M., 521
Coman, D. R., 242
Compston, N. D., 1128
Conard, V., 1226
Conrad, A. H., Jr., *557, 1050
Consigli, C. A., 1130
Cook, E. N., *915
Cook, F. E., Jr., *1136
Cooke, L., 1586
Cooley, D. A., 880, 1214
Cooley, R. N., 1047, 1122
Cooper, D. Y., 521
Cooper, G., Jr., *1077
Cooper, T., *14, 881
Corcoran, A. C., *1233
Cordice, J. W. V., Jr., 522, 1214
Cordier, N., 1226
Cornbleet, T., 1571
Cornish, P. E., 1488
Corrigan, K. E., 451
Cosby, R. S., 976
Cosgriff, S. W., *547
Cossa, P., 71
Costa, A., 1588
Costogan, W. J., 589
Cottrell, T. L. C., 172
Counihan, T. R., 57
Courville, C. B., 679
Coventry, W. D., *28
Crafoord, C., 1315
Crile, D. M., 60
Crile, G. W., Jr., 679
Crofton, J. W., 251
Cronin, D. J., *479
Cronkhite, L. W., Jr., 593
Crossett, E. S., 1580
Croucher, J. S., *479
Cudkowicz, L., 985
Culp, D., 240
Cummings, C., 599
Cummins, J. F., *480
Curtis, G. H., 675
Curtis, G. M., 66, 1205
Curwen, M. P., 1584
Custer, H. E., 1318
Cutler, S. S., 1575

D

Dadey, J. L., *723
Dameron, T. E., Jr., 250
Dameshek, W., 1059
Dammann, H. J., 1322
Damon, A., *622
Danus, O., 601
Dao, T. L-Y., 761
Daro, A. F., *1012
Das Gupta, C. R., 1486
Davids, A. M., 514
Davidson, L. R., 247
Davies, J. B. M., 597
Davies, J. J., 681
Davis, A. E., 237
Davis, C., 882
Davis, E., Jr., *782
Davis, F. W., Jr., 1478
Davis, H. S., *1156
Day, E., 57
Dean, A. L., *1347
DeBakey, M. E., 880, 1214
Debenham, M. W., 882
Decker, J. P., 1122
de Duve, C., 887
DeJong, R. N., *715
Delaney, J. H., 884
Delarue, L., 689
Delay, J., 1590
De Mattel, F., 1129
Deming, Q. B., 518, *1236
DeNardi, J. M., 675
Dencer, D., 1058
Dencker, P., 1590
Denk, W., 596
Denny, F. W., 593
Denny-Brown, D., 1120
Densen, P. M., 513
Dent, J. H., 683
de Peyster, F. A., 1478
Derbes, V. J., 762
Derra, E., 1223, 1224
Derrick, E. H., 1323
Deschamps, A., 767
Desneux, J., 1313
Deterling, R. A., Jr., 1315
Deirie, P., 1590
De Vahla, J. -L., 769
Dick, J. C., 1223
Dickey, L. B., 243
Dickinson, F. G., *921
Diefenbach, W. C. L., *17
Diengott, D., 252
Diez, L. F., 70
Dillon, H., *1015
Divry, A., 1126
Docton, F. L., 1203
Dod, K. S., 60
Doehner, G. A., 1403
Doenges, J. P., *1018
Doepfmer, R., 686
Döring, H., 1321
Doerner, A. A., *207
Dogliotti, A. M., 1225, 1488
Dollerup, E., 1324
Domino, E. F., *26
Donaldson, G. A., 1207
Donzelot, E., 254, 254
Doolan, P. D., 1053
Dorman, D. C., 251, 251
Douglas, R. G., *998
Dowling, J. L., 1407
Drachman, S. R., 513
Dragstedt, P. J., 690
Drake, M. E., *17
Drapiewski, J. F., 1211
Drayer, C. S., *1015
Dreese, W. C., 521
Driver, I. E., 1580
Driver, J. R., *1515
Dubarry, L., 1060
Duda, S., 679
Duffy, J., 1490
Duke-Elder, S., 597
Dumont, L. E., 1126
Duncan, C. G., *1345
Duncan, G. G., 1205
Dunn, H. G., 448
Dunsford, I., 765
Dutreix, J., 690
Dye, W. E., 589
Dye, W. S., 1208

E

Ebel, A., *10
Ecker, A., 592
Edgren, D. C., 979
Edmundson, W. F., 58, 58
Edwards, C. N., 59
Egan, R., 1204
Ehrlich, J., 881
Ekman, P., 59
Elisberg, E., 169
Elkins, H. B., 240
Elliott, J. L., *563
Ellis, F., 1584
Ellis, L. B., 677, 1209
Emerson, E. B., Jr., *920
Emerson, W. J., 680
Emery, J. L., 885
Emmett, R. O., 1315
Engel, F. L., 979
Engelhardt, H. T., 1210
Engell, H. C., 523
Engström, I., 767
Erasmus, L. D., 1583
Erickson, T. C., *636
Erlacher, P., 1594
Ernst, K. F., 1056
d'Eshougues, J. R., 176
Estrada, S. C., 883
Etzel, C. A., 235
Evans, A. S., 448

F

Faber, M., 255

Facquet, J., 175
Fahrlander, R., 985
Fairlie, C. W., *90
Fankhauser, A. M., 64
Farber, E. M., 1580
Farell, D. M., 733
Farrant, J. L., 1057
Faucompre, P., 888
Faust, L., 1218
Fay, T., (correction) 225
Fazio, M., 766
Feinberg, S. M., 682
Feinmann, E. L., 685
Feldman, D. J., *895
Feldman, W. H., 1041
Felici, A., 689
Felix, W., 602
Fellmann, H., 768
Felsen, J., *1069
Felton, W. L., II., 60
Fenner, F., 1057
Fenwick, T., 764
Ferencz, C., 63
Fergusson, J. D., 67
Fernández, A., 596
Ferrari, M., 596
Ferraro, G. M., 1588
Fey, H., 985
Field, L., 58
Finley, J. W., 760
Finnerty, J. J., 763
Fischer, R., 690
Fisher, A. A., 1119
Fisher, R. H., 62
Fishman, H. C., *642
Fishman, S. I., 64
Fitts, W. T., Jr., *901
Fleischmann, C. A., 514
Fleming, R., 66
Flocks, R. H., 240
Floyd, G., 590
Flynn, F. J., Jr., 1317
Fog, T., 1594
Foley, E. F., *211
Foley, W. T., 168
Folk, J. E., 174
Fomon, S. J., 448
Fontan, M., 253
Ford, L. T., *557
Forman, D. N., 1114
Forrest, R. L., *231
Forsee, J. H., 980, 1576
Forster, F. M., 63, *609
Fortin, P., 769
Fourestier, M., 601
Fox, J. R., 682
Francese, A., 599
Franckson, J. R. M., 1226
Frank, C. W., 680
Franks, L. M., 67, 1216
Fraser, D., 1222
Fraser, K., 1583
Fraser, R., 1409
Freedberg, A. S., 239, 1052
Freeman, L. S., 245
Frelick, R. W., 1047
French, J. D., 249
French, L. A., 682
Frick, P. G., 517
Friedman, A. I., 1313
Friedman, S., 173
Friend, D. G., *180
Frövig, A. G., 675
Frost, D. V., 174
Fulton, J. F., *482
Furcolow, M. L., 315, 1207
Furman, R. H., 239
Furth, J., 242

G

Gaze, E. L., 241
Gagliardi, P., 453
Gagnon, E. D., 986
Gaines, W., 242
Gale, G. S., 1585
Gale, R. G., 239
Gallois, P., 689
Gamble, C. J., *1019
Gamble, F. N., 242
Gammelgaard, A., 523
Gammon, G. D., 676
Gardner, W. J., *706
Garin, L., 152
Garland, H., 685
Garlock, J. H., 678
Gartland, J. J., 1314
Garvey, J. L., 1579
Geake, M. R., 985
Gear, J., 601
Gefel, A., 765
Geffen, D., 687
Geffen, D. H., 1217
Gelfer, J. S., *1360
Georg, J., 770
Gerard, J. E., 173, 1577
Gerlach, E., *553
Gershon-Cohen, J., *625
Gerstl, B., 59, 237
Getting, V. A., *265
Ghormley, K. O., *915
Gianturco, C., *1429
Gibb, W. T., Jr., 1316
Gifford, H., 518
Gilbert, C., 1322
Gilchrist, R. K., 1478
Gill, R. J., 1205
Gillman, J., 1322
Ginsberg, H., 1132
Ginsburg, I. W., 1120
Girard, J., 888
Girdwood, R. H., 765
Given, W. P., *998
Gjersøe, A., 255
Glaser, J., *620
Glover, R. P., 1209
Goldberg, H., 246
Golden, R., *1431
Goldfarb, P. M., 1311
Goldfien, A., 248
Goldman, A., *553
Goldner, F., Jr., 759
Goldring, W., *1245 (correction) 1460
Goldwater, L. J., 169
Gollin, H. A., *1012
Goodman, R. D., *462
Goodrich, W. A., Jr., *1424
Gordon, A. J., 976
Gordon, E. B., *1444
Gordon, E. J., *552
Gottlich, J., 1132
Grabstald, H., *563
Graham, J. N., 680
Graham, M. A., 65
Grant, F. C., *22, *1015
Grant, M. P. S., 600
Grant, R. A., 522
Grantham, E. G., 167
Grassi, G., 985
Grayston, J. T., 515, 1207
Greeley, P. W., *201
Green, T. W., 1404
Greenberg, M., 884
Greene, J. A., 1210
Greenspan, F. S., 518
Greifenstein, H., 603
Gremliza, L., 771
Griffith, G. C., 976
Griffith, P. C., *905
Grillial, J.-P., 888
Grinberg, M., 690
Griswold, C. M., 1404
Grivet, A., 1592
Groh, D., 529, 1123
Groen, J., 888
Gross, R., 1582
Gross, R. J., 240
Grossman, H. J., *201
Grove, W. J., 1208
Gruning, W., 981
Guglielmini, G., 1488
Guidry, D. J., 520
Guillaume, J., 768
Guiot, G., 888
Gulledge, W. H., 250
Gunz, F. W., 1049
Gurdin, M., 594
Gurdjian, E. S., 757
Guterman, H. S., 1203

H

Haarhoff, J., 1594
Hässig, A., 254
Hafkenschiel, J. H., 880, *1502
Hagens, E. W., 165
Hagman, F. E., 980
Hahn, G. A., 753
Haig, C., 586
Hailey, H., 1213
Haines, S. F., 585
Halde, C., 754
Hall, B., 57
Hall, B. H., *615
Hall, F. G., 591
Hallberg, O. E., *1073
Hal ervorden, J., 1582
Hallock, H., 1314
Halse, T., 687
Hamilton, W., 762
Hammon, W. M., 752
Hammond, J. H., 973
Hansen, C. J., 1324
Hansen, J. L., 690
Hansen, K. B., 67
Harden, K. A., 62
Hardy, H. L., 509
Harford, C. G., 1484
Harken, D. E., 677, 1209
Harrell, J. B., 249
Harrington, S. W., 517
Harris, R. C., *1333
Harrison, L. B., 246
Hartl, H., 770
Hartmann, O., 1058
Hartz, H., 1127
Hauser, H., 166
Hawn, C. Van Z., 1132
Haxton, H. A., 167
Hayden, H. S., 451
Hayes, H. T., 1115
Hayes, M. B., 1481
Haymaker, W., 171
Hazard, J. B., 679
Head, E. S., *1266
Head, J. R., *550
Heather, T. J., 1120
Heaton, T. G., 1486
Hedges, T. R., Jr., 1574
Hellig, W., 255
Hellmeyer, L., 983
Helmark, J. J., 592
Hein, J. W., 1571
Hejtmanclk, M. R., 1479
Hellman, L. M., 753
Hellwig, C. A., 521
Helper, H. N., 1046
Helpern, M. M., 1483
Henninger, H., 170
Henricke, S. G., 1380
Heptinstall, R. H., 600
Herholz, G., 1593
Herrick, J. F., 517
Herrmann, G. R., 1479
Hersh, A. H., 166
Hess, W. C., 1053
Hewitt, W. L., 1053
Hicken, N. F., 977
Hickey, R. C., 1478
Hig ins, C. C., 1054
High, R. H., 245
Hightower, N. C., Jr., 676
Hilden, T., 770
Hilker, R. R. J., *5
Hill, E., 585
Hills, A. G., *1502
Hirshleifer, J., 64
Hirson, C., 685
Hjorth, H., 690
Hobby, G. L., 240
Hodges, P. C., *1417
Hodgkins, T. E., *182
Hodgson, J. E., *271
Hoffert, P. W., 1121
Hoffman, J., 753
Holgné, R., 1132
Holder, E., 885
Holldack, K., 686
Holoubek, J. E., *1018
Holtz, F., 767
Horsley, G. W., 250
Howell, T. H., 1583
Hranilovich, G. T., 238
Huang, N. N., 245
Huddleston, O. L., 1208
Huggert, A., 452
Hughes, J. P., *1438
Hultgren, H., 681
Humphreys, G. H., 246
Husfeldt, E., 523
Hutcheson, J. M., Jr., 1479
Hutchison, A. M., 765
Hutchison, H. E., 1583
Huth, E., 1215
Hyman, A. S., 1304
Hynes, J. F., 1047

I

Ingalls, T. H., 1483
Inglis, J. A., 1323
Ingram, T., 1406
Innes, J., 252
Irby, R., *103
Isaacson, N. H., 249
Ivy, R. H., 235
Izar, G., 1591

J

Jackson, R. L., 1574
Jackson, W. P. U., 1217, 1217
Jaeger, R., *633, *792
Jaffe, H. L., *1499
Jahnke, E. J., Jr., 1581
James, T., 1587
James, W. E. S., *545
Jamison, W. L., 756, 980
Jamra, M. A., 1215
Janes, J. M., 166
Jaxton, O. H., 1209, 1576
Jeffers, W. A., 880, 1403, *1502
Jeffreys, N. C., *1095
Jeffrey, M. R., 241
Jeffrey, R. B., *1422
Jellife, D. B., 453
Jensen, K. A., 1594
Johns, R. B., 245
Johnsen, L., 754
Johnson, A. A., 244
Johnson, A. L., 63
Johnson, B. A., *1253
Johnson, B. B., *1236
Johnson, E. A., *1266
Johnson, W. M., 235
Johnston, E. V., 166
Johnstone, D. E., *620
Joiner, C. L., 983
Jolliffe, N., 880
Jones, A. T., 67
Jones, F. S., 1586
Jones, P. N., *262
Jordan, S. M., *1505
Josiukas, A., 1585
Julian, O. C., 1208

K

Käss, A., 1224
Kaiser, G., 603
Kalk, H., 1218
Kammer, A. G., *723
Kanoul, F., 1131
Kaplan, I. I., 64
Kaplan, S. A., 448, 1119
Karall, F., 1406
Karelitz, S., 592
Karn, H. M., 1490
Karsner, H. T., *1356
Katz, J. H., 520
Katz, L. N., 169, *1075
Kaufman, H., 254, 254
Kazmierski, R. H., 235
Kearley, E. J., 1488
Keech, M. K., 1586
Kegel, A. H., 1304
Keitel, H. G., *799
Keitel, N. B., *799
Keith, N. M., *1240
Kelley, E. P., 1210
Kelley, G. E., 680
Kelly, H. G., 1574
Kendall, R. E., *90
Kennamer, R., *553
Kennedy, B. J., 243, 680
Kerdasha, R., 1053
Kergin, A. J., 1486
Kern, R. A., *157
Kerr, A., Jr., 762
Kerr, H. D., 240
Key, J. A., 759
Khedroo, L. G., *557
Kiaer, I., 1594
Kiely, J. M., 594
Kilgore, A. R., 66
Kimbrough, J. C., *1436
King, G., 676
King, J. C. H., Jr., *31
King, M. B., 983
King, W. C., 1403
Kingsley, G. R., *462
Kinsell, L. W., 684
Kinsella, V. J., 1222
Kirschner, P. A., 678
Kisch, B., 1472
Kiaer, T., 690
Klassen, K. P., 1318
Klemptner, H. E., *560
Klinke, K., 1215
Klotz, H. P., 453
Knowles, F. W., 69
Knowles, H. C., Jr., 1119
Kohn, A., 516
Koller, F., 1061
Kook, H., 765
Korubilseh, I. H., 1208
Korpman, R., 1577
Kossmann, F., 1127
Koster, M., 888
Kountz, W. B., *777
Koven, B., 1472
Kozokoff, N. J., 449
Kraepellen, S., 767
Kratzer, G. L., *1165
Krebs, C., 1408
Kreis, B., 70, 254
Kresky, B., 169
Kretchmer, H. E., *1156
Kreyberg, L., 769, 1129
Kronfeld, P. C., 590
Krook, H., 1591
Krücke, W., 603
de Kruijff, G., 69
Krusen, F. H., 517
Kryger, J., 1060
Krynsky, S., 687
Kuczko, L., 1586
Kuhn, E., 686
Kummer, B., 887
Kunstadter, R. H., 1203
Kupperman, H. S., 237
Kurland, G. S., 239, 1052
Kuske, A., 764
Kyle, L. H., 1053

L

LaDue, J. S., *712
LaGorce, J. O., 974
Laham, J., 254
Lall, S., 592
Lam, C. R., *552, 1571
Lamarca, V., 767
Lamb, J. H., *1509
Landé, K. E., *179
de Langen, C. D., 1324
Langendorf, R., 1400
Langford, H. G., 1123
Langford, R. B., *1018
Langley, L. L., 750
Lanier, J. C., 520
Lans, H. S., *1012
Lapin, L., *788
von La Rosée, R., 887
Larzelere, H. B., 758
Lasser, R. P., 976
Latapi, F., 883
Lattimer, J. K., 172, *1347
Lazaro, J., 1407
Leader, S. A., 65
Leavitt, H. C., 509
LeBouvier, G. L., 1037
Ledlie, E. M., 523
Lee, C. M., Jr., 1312
Lee, L. W., *782
Lefebvre, L., 1126
Leger, Lee, 170
Leger, Lucien, 1131
Leggerton, C. W., Jr., 237
Lehmann, M. 1406
Leland, C. C., *1270
Lenert, T. F., 240
Lennox, M. A., 986
Leone, N. C., *17
Lepper, M. H., 1574
Lerebollet, J., 601
Lerman, F., 172
Lerman, P., 172
Leshin, N., 450
Lester, W. M., *695
Letman, H., 1593
Letourneau, C. U., *476
Leuterer, W., 1060
Levine, H. D., 1312
Levinson, D. C., 976
Levy, H., 243
Levy, S., *1260
Lewin, W., 1587
Lewis, L., 684
Lewis, L. W., 50
Lewison, E. F., *905
Lichtenstein, M. E., *557
Lichtenstein, M. R., 754
Lichow, A. A., 60
Lillehei, C. W., 1402
Lima, S. de O., 1490
Limón, R., 764
Lindskog, G. E., 60
Linton, R. R., 168, 1124
Liu, Y., 886
Livingood, C. S., *1266, 1403
Llavona, J. A., 690
Lobitz, W. C., Jr., 512
Löfgren, S., 981, 981
Loesser, A., 1058
Logan, J., 659
Loosli, C. G., 756
Lorant, A., 1577
Lorant, G. J., 1577
Lorenzini, L., 452
Lotte, 1071, 70
Lovingood, C. G., 1205
Lowe, K. G., 766
Lozada, B. B., 984
Lubon, H., 1212
Lubschez, R., 1046
Lucà, S., 68
Ludwick, R. W., 449
Luetscher, J. A., Jr., *1236
Luft, R., 171, 1123
Lull, G. F., 858
Lumbroso, P., 453
Lund, E., 602, 602
Lundgood, L. E., *557
Lundin, B. G., 175
Lundin, S., 1129
Lundy, J. S., 166
von Lutzki, A., 1226
Luxton, R. W., 525
Lyall, A., 525
Lynch, W. J., 754

M

McAllister, A. J., 977
MacAusland, W. R., Jr., 1314
McBryde, R. M., 600
McCain, J. R., *695
McCarroll, H. R., *536
McClure, F. J., 174
McCormick, E. J., *133, 730, *857, *1178, *1525, *1529
McDermott, W. V., Jr., 173
McDevitt, E., 168
McDonald, J. E., 590
McDonald, J. R., 243
McDowell, F., 513
McEnery, E. T., *627
McFarland, R. A., *622
McGregor, M., 879, 1593
McIntire, F. C., 682
McIntyre, W. I. M., 1586
McKay, G. L., 1206
McKeown, T., 1057
Mackie, J. A., 1403
Mackinnon, J. E., 1582
Malamud, N., 1578
McLaurin, W., 683
Maclean, K. S., 983
McLean, L. D., 762
McLeod, C. P., 761
McLoughlin, C. B., *182
MacMillan, B., 1057
McNeeley, W. F., 1209
McNeer, G., 521
McNicholl, B. M., 525
Macpherson, R. S., 252
McRae, D. L., 588
McVay, L. V. Jr., 59, *95
Magarão, M. F., 1490
Magalh, T. B., 1041
Magee, K. R., *715
Magee, R. B., 1054
Magnani, B., 1219
Magnuson, H. J., 761
Mahady, S. C. F., 754
Mahlin, M. S., 676
Maier, E., 255
Mainzer, F., 1405

Malbran, J. L., 886
Malewitz, E. C., *1446
Malkiel, S., 682
Malmström, L., 1485
Maltby, G. L., *17
Mandl, F., 596
Mangun, C. W., Jr., 974
Manning, P. R., 173, *262
Maraschio, P., 768
Marbarger, J. P., 1401
de Marchi, A., 176
Marchis, E., 1588
Marcus, M. D., 1050
Marlani, A., 521
Marinoni, F., 1218
Markson, D., 165
Marocco, F., 1588
Marquardt, P., 983
Marques, J. M., 170
Marsault, J., 601
Marshak, R. H., 1313
Marson, F. G. W., 1590
Martensen-Larsen, O., 1484
Martin, F. A., 757
Martin, H. L., 513
Martin, W. J., 1577
Martini, G., 68
Masi, A., 1129
Mason, R. E., 1478
Master, A. M., 1115, 1122, *1499
Mathieu de Fossey, B., 71
Matson, D. D., 1483
Matter, M., 1061
Matthes, M., 983
May, J. R., 1487
May, S. H., 1570
Mayer, E., *700
Mayer, C., 1584
Mayer, H., 1576
Mayer, R. A., *1002
Mayock, R. L., *1094
Mazars, G., 768
Mazars, Y., 768
Meade, G. M., 593
Measroch, V., 601
Meckstroth, C. V., 1205
Meigs, J. Y., 167
Meilman, E., *540
Meissner, G., 1593
Meleney, F. L., *1253
Merendino, K. A., 760
Merkle, R. W., *20
Merricks, J. W., 172
Merrill, S. J., 1206
Meyer, B. M., 588
Milburn, A. A., 1056
Milch, E., 1204
Miller, D., 238
Miller, F., 1055
Miller, F. L., 1579
Miller, G., 169
Miller, G. A., *1429
Miller, H. G., 512
Millikan, C. H., 585
Mills, L. C., 595, 1311
Mills, R. A., *910
Mitchell, J. D., Jr., *1149
Mitchell, R. G., 597
Mithoefer, J., *1097
Mixter, C. G., 1049
Mixter, C. G., Jr., 1049
Molgaard, B., 1324
Moller, H., 770
Moersch, H. J., 243
Mokychic, W. E., 1211
Mollin, D. L., 1485
Monnoyer, E., 396
Monroe, W. M., 1319
Montgomery, T. A., 1212
Moon, V. H., 589
Moore, H. G., Jr., 676
Moore, K. E., 75
Moore, R. L., 246
Moore, R. W., 1208
Morales, P. L., *1431
More, J. F., *1007
Mori, S., 1129
Morris, J. McL., 515
Morrison, B., 524
Morrison, L. M., 1580
Mortensen, H., 766
Morville, P., 523
Moschcowitz, E., *194
Moscovitz, H. L., 976
Moseley, ., 1318
Mosovich, A., 1588
Motulsky, A. G., 882
Mousel, L. H., *159
Movitt, E. R., 59, 237
Moxhis, H. J., 249
Moyer, C. A., 167
Moyer, J. H., 595, 1311
Müller, E., 1218
Müller, F., 1594
Muench, H., *1
Mulholland, J. H., 66
Muller, G. M., 1220
Munk-Andersen, G., 255
Murdock, T. P., *1142
Murley, R. S., 1584
Murphy, E. S., 245
Murphy, F. D., 449
Murphy, R., 585
Murphy, T. O., 762
Murray, E. G., 1577
Murray, R., *17, 1055
Murray, R. C., 63
Murthi, G. V. S., 983
Myant, N. B., 1487
Myers, J. M., Jr., *1015

N

Nabatoff, R. A., 1041
Nadas, A. S., 976
Narayana Rao, D., 983
Nassim, J. R., 524
Nathanson, I. T., 243, 680
Naylor, G. K. E., 599
Necheles, H., *1095
Needham, G. M., *915
Neff, W. B., 1576
Nelson, A. A., 170
Nelson, Richard S., 448
Nelson, Robert S., 753
Nelson, W., 977
Neptune, W. B., 246, 980
Netter, A., 1592
Nettleship, A., 1040
Neuhauser, E. B. D., 976
Neustadt, D., *788
Nevius, W. B., 593
Nevola, V., 1588
Nicholson, D., 59
Nicosia, A. J., *557
Nielsen, J. M., 679
Niemeyer, H., 601
Nieweg, H. O., 1589
Nilasena, S., *1266
Nora, E. Jr., *1012
Norbis, A. L., 886
Norlén, G., 758
North, E. A., 984
Nulsen, F. E., *1015
Nurick, A. W., 1583
Nutt, R. L., *918

O

Oberkircher, O. J., 1050
O'Brien, H. A., *1149
O'Connell, F. B., Jr., *706
O'Conor, V. J., *532
Oddoze, L., 1408
Odel, H. M., *1240
O'Doherty, D., 63
O'Keefe, J., 978
Olansky, S., 58, 58
O'Leary, C. M., 587
Ollner, L., 450
Oliphant, J. W., *17
Olivercrona, H., 171, 758, 1123
Ollagnier, C., 1490
O'Loughlin, B. J., 755
O'Neill, T. J. E., 1209
Orgain, E. S., *12
Osborn, L. A., *259
Osgood, H., 61
den Oudsten, S. A., 888

P

Palne, J. R., 1481
Pals, E., 1586
Paletto, A. E., 253
Palladino, V. S., 979
Palmer, A. J., 1126
Palmer, E. D., 519, 1581
Palmer, G. R., 1488
Palmer, R. S., *1
Palmer, W. L., 1199
Palumbo, L. T., 516, 1048
Pangman, W. J., 594
Paul, A., 688
Pannacciulli, I., 1321
Papacharalampous, N., 1590
Parentela, A., 1215
Parfentjev, I. A., 1581
Parks, J., 248
Parmenter, F. J., 1050
Parmer, L. G., *1172
Parry, N., 165
Parsons, C. G., 1057
Parsons, R. L., 592
Parsons, W. B., Jr., *14, 881
Patel, J., 175
Paterson, J. H., 687
Patey, D. H., 1583
Patterson, J. F., 1406
Patterson, R. W., 984
Patton, R., 1295
Patz, I. M., 601
Paul, R. E., 1018
Payet, P., 1131
Pearson, M. M., *1015
Pedersen, A., 523
Pedowitz, P., 753
Peirce, E. C., II., 681, 757
Pelikan, E. W., *26
Pellegrini, C., 1224
Pender, J. W., *1073
Pendergrass, E. P., 1121
Pene, P., 1131
Penn, J., 601
Penrod, K. E., 591
Pernot, C., 1130
Perry, J. W., 1128
Perry, W. D., 593
Pestel, C. V., 1401
Pestel, M., 689
Peters, B., 1321
Petersen, E. S., 1209
Peterson, E. W., *1434
Petit-Dutaillis, D., 888
Petrie, J. G., 1221
Petrie, L. M., *182
Phillips, R. A., *1356
Pick, J. F., 1406
Pickrodt, G., 771
Piel, C. F., *1236
Piersol, G. M., 1208
Pilkington, J. W., *695
Pilkington, T., 524
Pincus, P., 1323
Piozzi, G., 1324
Piper, P. G., *215
Pirovano, L., 985
Pirrung, E., 1127
Pitts, F. W., 589
Placak, J. C., Sr., *795
Plas, G., 1131
Plenk, A., 770
Plesch, S. A., 70
Pluvinage, R., 601
Pock-Steen, P. H., 1593
Ponsford, J., 251
Popper, Hans Leopold, *1095
Porter, J. E., *17
Porter, R. W., 249
Poth, E. J., *1516
Poutasse, E. F., 1051
Powell, T. O., *1341
Power, M. H., 449
Poynton, O., 1380
Prato, V., 1589
Prettl, K., 770
Price, R. D., *784
Priestley, J. T., 676
Prinzmetal, M., *553
Prior, J. A., 1203
Propst, H. D., 1480
Pucket, T. F., 980
Pulaski, E. J., 1048
Purdy, A., 681
Putnam, T. J., (correction) 573
Putney, F. J., 978

R

Rafferty, E., *1347
Raffi, A. B., 680
Raimo, L., 687
Rall, J. E., 1203
Ramos, M. M., 66
Ramsay, H. H., 590
Ramsey, R. H., 759
Raney, A. A., *1434
Raney, R. B., *1434
Rao, K. V. S., 756
Rappaport, I., *700
Ratner, F., 1055
Ravdin, I. S., *901
Ravina, A., 689
Rawson, R. W., 1203
Raynaud, R., 176
Rechtman, A. M., *625
Redner, W. J., Jr., 241
Rees, L., 1221
Reese, A. J. M., 67
Reich, T., 690
Reinhardt, D. J., 1205
Reitman, H., *1360
Remy, M., 1130
Renner, W. F., *102
Reuling, J. R., *1527
Reyes, A. C., 754
Reynolds, J., *642
Reznick, E., 51
Rhoads, P. S., *5
Rhodes, A. J., 598
Ribbo, J. B., 883
Rich, C., Jr., 513
Ricketts, H. T., 1209
Rico, A. L., 58, 58
Ricke, F. E., *198
Riemenschneider, P. A., 592
Rigney, T. G., 57
Rigoletti, L., 68
Riley, G. M., *1018
Ripon, J. E., 1323
Ripstein, C. B., 1103
Risser, J. A., 249
Rist, N., 254
Ritchie, J. M., 1223
Ritter, J. S., 244
Rives, J. D., 1315
Rivoire, Z. C., 240
Robbins, J., 1203
Robbins, R. L., 1316
Robbins, S. L., 1122
Robers, H., 1585
Roberts, E., 448
Roberts, M., *268
Robinson, B., 253
Robinson, H. M., Jr., 1213, 1482
Robinson, R. H. O. B., 597
Rocca, J. B., 602
Roche, M., 253
Rodgers, D. L., 760
Rodriguez, O., 883
Rolfsen, U., 1130
Roman, G., 51
Romconi, G., 599
Roque, F. T., 449
Rose, E., 1574
Rose, S., 1485
Rosenbaum, H. D., 976
Rosenbaum, H. E., 1484
Ross, C. A., 1578
Ross, G. I. M., 1485
Rosza, S., 240
Roth, G. M., 676
Roth, W., 1225
Rothenberg, S. F., (correction) 573
Rothmann, B. F., 522
Rousselot, L. M., 1403
Roy, T. E., 1585
Routh, J. I., 1574
Royer, R. Q., 247
Ruben, J. E., *1002
Rubenow, R., 765
Rubens-Duval, A., 888
Rubin, D., 1208
Rucker, E., 1311
Rudin, L. N., *479
Rümelin, K., 1585
von Rütte, B., 254
Ruffin, J. M., 237, *1159
Rumolo, R., 1321
Rusk, H. A., 509, *787
Russek, H. I., *207
Russo, L., 1218
Ruzicka, F. F., 1403
Ryan, O., Jr., 749

S

Sachs, A. R., 165
Sacks, M. O., 1571
Sadove, M. S., *201
Sala, G., 1491
Sala, I., 1224
Salas, M., 1320
Salce, H., 1320
Sales, L. M., 518
Salm, R., 1128
Saltzstein, H. C., 676
Salvioli, G., 688
Sampalo, J. A., de M., 687
Sanders, F. K., 597
Sandy, H. R., 174
Sansone, G., 1129
Santenoise, D., 253
Saphir, O., 1400
Sawitsky, A., *1172
Saxton, J. A., Jr., 246
Sayago, G., 602
Sborov, V. M., 1581
Scarborough, W. R., 1478
Schaaf, R. S., 57
Schaefer, J. H., 974, 1114
Schaefer, L. E., 513
Schaffer, N., 589
Scheiffey, C. H., *14, 881
Scheinberg, S. R., 676
Schiavetti, L., 68
Schindler, R., 1313
Schilderdup, H., 1589
Schlesinger, P., 879
Schlicke, C. P., 884
Schlosser, R. J., 676
Schmidt, M. A., 982
Schmidt, E., 1322
Schmidt, H., 1585
Schmidt, M. C., *214
Schmidt-Voigt, J., 598
Schneckloth, R. E., 1052
Schneider, P. J., 245
Schneidrzik, W. E. J., 764
Schnur, S., 168
Schracr, H., *625
Schrum, D. I., 520
Schuck, M. H., 588
Schultz, H., 1489
Schwab, R. S., *1270
Schwartz, G., 64
Schwartzman, J., 1212
Schweizer, O., 1213
Scott, E. L., 1576
Scott, R. B., 245
Scudder, J., 522, 1214
Sealy, W. C., 1214
Seaman, W. B., *630
Seddon, H. J., 1220
Seevers, M. H., *1329
Seibert, P., 175
Seiler, H. E., 1586
Seip, M., 1408
Sellers, A. M., *1502
Selye, H., 1115
Selzer, A., 681
Senot, R., 888
Serianni, E., 521
Settimi, A. L., 449
Seulberger, P., 1321
Shafer, W. A., 241
Shapira, T. M., 450
Shapiro, A., 1213
Shapiro, M., *17
Shaw, R. R., 1580
Sheffer, J., 1481
Sherman, A. I., *630
Sherman, J. B., 886
Shiels, D. O., 1488
Shimada, F. T., 598
Shinefield, H. R., 591
Shirabe, R., 1482
Shiraki, H., 171
Shuff, F. L., 1479
Shumway, N. P., *545
Sidi, E., 1131
Sieber, H. A., *12
Sieber, P. E., 761
Siegel, A. C., 519
Siegel, M., 884
Siemieński, J., 585
Sigler, L. H., 664
Silber, E. N., *1075
Silver, R. A., 1125
Silverman, J. J., 64
Silverman, S. H., 1483
Simon, E. P., *98, 1115
Sinclair-Smith, B. C., 1126
Sindelar, J., *102
Singian, E., 169
Sjögren, B., 1123
Sjögren, H., 452
Skelton, J. M., 595, 1311
Slaughter, D. P., 1480
Sloan, H., 758
Sloan, R. D., 1047
Smelkal, W., 1480
Smiley, T. T., 173
Smith, E. E., *1360
Smith, E. K., 1574
Smith, F. H., *1505
Smith, G., 1581
Smith, H. W., *1512
Smith, K. M., 514
Smith, L. B., *1015
Smith, O. W., 1581
Snead, H. H., 1318
Snoeck, J., 982
Snyder, M. H., 586
Snyder, W. H., Jr., 586
Soffer, L. J., 173
Soloff, L. A., 1205, 1576
Sommer, A. W., *1424
Sorkin, S. Z., 1317
Soucheray, P. H., 755
Sougin-Mibashan, R., 1217, 1217
Southcott, R. V., 1587
Southwick, H. W., 1480
Speer, F. D., 66
Spies, T. D., *185
Spigelman, L., *1362
Spink, W. W., *1162
Spilotta, E., 59
Spivack, L. L., 172
Sprague, R. G., 449
Sprinz, H., 448
Sprunt, J. H., 59, *95
Spurling, R. G., 167
Staffieri, J. J., 70
Stahl, A., 1408
Stanley, N. F., 251, 251
Stashitz, W. J., 1050
Stauffer, M. H., 451
Stecher, R. M., 166
Steenken, W., Jr., 589, 593
Stefanini, M., 1059
Steiger, W. A., 1120
Stein, I., 883
Steinberg, A. G., 513
Steinbrocker, O., *788
Steiner, P. E., 1209
Steinthorsson, I., 59
Stevenson, A. H., 515
Stevenson, J. K., 676
Stewart, A., 982, 1127
Stewart, B. D., 586
Stewart, I. M. G., 687
Stewart, R. O., 599
Stewart, S., 251
Stibbe, P. D., 453
Stickney, J. M., 594
Stiefel, E., 1407
Stiefel, R., 1061
Stillians, A. W., *560
Stochino, A., 1215
Stokes, J., Jr., *17
Stoll, R. L., 1584
Storck, H., 1132
Storey, C. F., 522
Stout, A. P., 246
Strähhuber, F., 1489
Strauss, A. F., 1319
Streiffer, M., 252
Studdert, T. C., 524
Su, H. H., 590
Suermondt, W. F., 981
Suess, J. E., 522, 1214
Sugar, O., *201
Sullivan, B. H., 241
Sullivan, F. L., 513
Svien, H. J., *784
Swaab, L. L., 767
Swain, R. H. A., 597
Swan, H., 586, *1081
Swenson, P. C., *1122
Szlazak, J., 1584

T

Tabah, E. J., 521
Tablante, T. G., 1127
Tanner, E., 1407
Taquini, A. C., 70, 984

Tardieu, Y., 1590
Taubenhaus, M., 450
Taverner, D., 685
Taylor, H. C., 522
Taylor, H. E., 1479
Taylor, R. M., 1223
Tedeschi, C. G., 1483
Teloh, H. A., 56
Tempel, C. W., 589, 1576
Terplan, K., 1481
Texter, E. C., Jr., 237, *1159
Thevenard, A., 170
Thomas, E. W., *718
Thompson, G. J., *1337
Thompson, H., *1162
Thorek, P., 244, *703
Thorén, L., 1129
Thorn, N. A., 1060
Tibbetts, D. M., 243
Tichter, E., 771
Tillisch, J. H., 173
Tinacci, F., 1592
Tocantins, L. M., 882
v. Törne, H., 1582
Tøsning, K., 1594
Tolstoi, E., *998
Tonge, J. I., 1323
De Toni, G., 1223
Torcivia, S. S., 1380
Tormey, D. M., 241
Torres Oliver, L. J., 1216
Tosetti, D., 452
Toto, P. D., 247
Totten, R. C., 246
Tow, P. M., 1587
Townsend, T. E., 591
Trabucco, A., 1061
Tracy, S., 1217
Tracy, S. M., 687
Trainito, R., 1589
Traut, E. F., *26
Trimble, F. H., *805
Trimble, H. G., 243
Trimble, I. R., *1143
Trimpi, H. D., *1249
Tubiana, M., 690
Tucker, B. E., 1206
Tucker, E. J., 66
Tulloch, J. A., 168
Tulsky, A. S., 1203
Tupikova, N., 1209
Turkel, H. W., *1086
Turnbull, F. W. A., 251
Turner, F. M., 1216
Turner, J. W. A., 1222
Turner, R., 69, 69
Tyler, E. T., *1351

U

Uchimura, Y., 171
Uhl, H. S. M., 1052
Undurraga, O., 601
Unger, L. J., *1444
Urbach, K. F., *207
Uricchio, J. F., *548
Usteri, C., 1061
Utterback, R. A., 171

V

Vachon, A., 1592
Vail, J. R., 1125
Valenti, V., 985
van Baaren, H. J., *636
van Balen, G. F., 1489
van Doeren, F., 1126
van Duzen, R. E., *1345
van Guilk, F. H., 1224
van Ordstrand, H. S., 675
van Schouwen, M., 888
van Veelen, A. W. C., 453
van Wisselingh, C. J., 69
van Wyk, J. J., 882
Vang, R. R., 1121
Vareo, R. L., 1402
Varga, C., 50, 1203
Vecchietti, G., 1591
Veenema, R., *1347
Venkateswarlu, P., 983
Verjaal, A., 1224
Vettiger, K., 254
Viallier, J., 689
Viau, A., 979
Vlets, H. R., *1273
Villa, L., 1491
Villarroya, P. F., 690
Vimtrup, B., 770
Vineberg, A., 238
Virtue, R. W., 586, *1081
Vizoso, A. D., 597
Vlasis, G. J., 250
Voyles, C. M., *12

W

Waddell, W. R., 61
Wade, F. A., 1319
Wade, H. J., 685
Walker, R., 1579
Walker, R. P., 1046
Walker, S. H., 587
Wallace, A. T., 251
Wallace, H. J., 1058
Walmer, C. R., 60
Walsh, E. N., *1305
Walter, J., 1060
Walters, W., *993
Wang, C. C., 61
Wang, H-H., 680
Wang, P., 1574
Wangensteen, O. H., 1317
Wannamaker, L. W., 593
Wanner, J., 1407
Warin, J. F., 597
Wartenberg, R., 1115
Waterfall, W. B., 1405
Watson, C. W., 1120
Watson, E. M., 686
Weatherhead, D. S. P., 686
Weber, H., 687
Webster, B., 513
Webster, J. E., 757
Wechsberg, P. H., 1101
Wégria, R., 680
Weigand, W., 71
Weille, F. L., 1121
Weiner, A. E., 1206
Weiner, J. G., 973
Weinstein, M., *268
Weis, F., 70
Weiser, N. J., 59
Weiss, R. S., 1050
Weisse, K., 603
Welch, C. E., 1207
Wells, W. H., 1125
Wendland, W., 770
Wense, G., 1405
Wenzl, M., 1405
Wermer, P., 731
Werner, K., 71
Wespi, H. J., 176
Westcott, F. H., 749
Westerborn, A., 175
Westropp, C., 1127
Wexler, D. J., 516
Weyand, E., 1226
Weyer, F., 771
Weyher, R. F., *639
White, M. S., *20
White, P. D., 57, *75
Whiteley, W. H., *633
Whiteside, C. G., 1583
Whorlskey, F. G., *562
Wiener, A. S., *1444
Wiesbader, H., 237
Wilbrandt, R., 166
Wild, J., 1203
Wildführ, G., 1408
Wilkin, P., 982
Wilkins, L., 1483
Wilkinson, M. C., 1220
Williams, B., 599
Williams, C. D., *1280
Williams, D., 585
Williams, I. G., 1584
Williams, R. E. O., 1323
Williamson, M. M., 1128
Williamson, P., *164
Willis, G. C., 685
Wilson, B. D. R., 1323
Wilson, C., 1587
Wilson, M. G., 1046
Winkler, C., 764
Winston, J., 752
Wirts, C. W., *1004
Wisenbaugh, P. E., *545
Wisham, L. H., *10
Wissfeld, H.-J., 981
de Wit, J. C., 1487
Withey, J. L., 1217
Witkind, J., 1582
Wittmer, S. C., 516
Wolarsky, W., *1069
Wolferth, C. C., *1502
Wolinsky, E., 589
Wolter, H. H., 1219
Wood, J. P., Jr., 1053
Wood, W., 598
Woodard, G., 170
Woods, M. C., 242
Wren, J. C., *918
Wright, I. S., *98, 1115
Wróblewski, F., *712
Wurzel, H. A.,*1094

Y

Yarnis, H., 1313
Yohalem, S. B., 1304
Young, F. H., 985
Youssef, A. F., 600
Yuhl, E. T., 1319

Z

Zaontz, J. B., 1212
Zarafonetis, C. J. D., 1120
Zatuchni, J., 1205, 1576
Zeavin, I., *1081
Zeligman, I., 1213
Zetzel, L., 450
Zheutlin, A., 1578
Zielinski, J., 675
Zieve, L., 585
Zint, F., 1592
Zintel, H. A., 880, 1403, *1502
Zion, M. M., 879, 1593
Zohman, B. L., *207
Zollinger, H. U., 768, 1591
Zucker, H. D., *895, 1041
Zweifler, B., 245

V 15
1951

INDEX TO PAGES

OF THE JOURNAL, ACCORDING TO WEEKLY ISSUES—VOLUME 153, SEPTEMBER-DECEMBER, 1953

Pages	No.	Date
1- 74	1	Sept. 5
75- 178	2	Sept. 12
179- 258	3	Sept. 19
259- 450	4	Sept. 26
457- 528	5	Oct. 3
529- 608	6	Oct. 10
609- 694	7	Oct. 17
695- 776	8	Oct. 24
777- 894	9	Oct. 31
895- 992	10	Nov. 7
993-1068	11	Nov. 14
1069-1142	12	Nov. 21
1143-1232	13	Nov. 28
1233-1328	14	Dec. 5
1329-1416	15	Dec. 12
1417-1498	16	Dec. 19
1499-1656	17	Dec. 26

Education Number: Sept. 12
St. Louis Clinical Meeting, Program: Oct. 31
Proceedings: Dec. 26
Reports of Officers: Oct. 31

Internship and Residency Number: Sept. 26
Postgraduate and Continuation Course: Dec. 12

153
953